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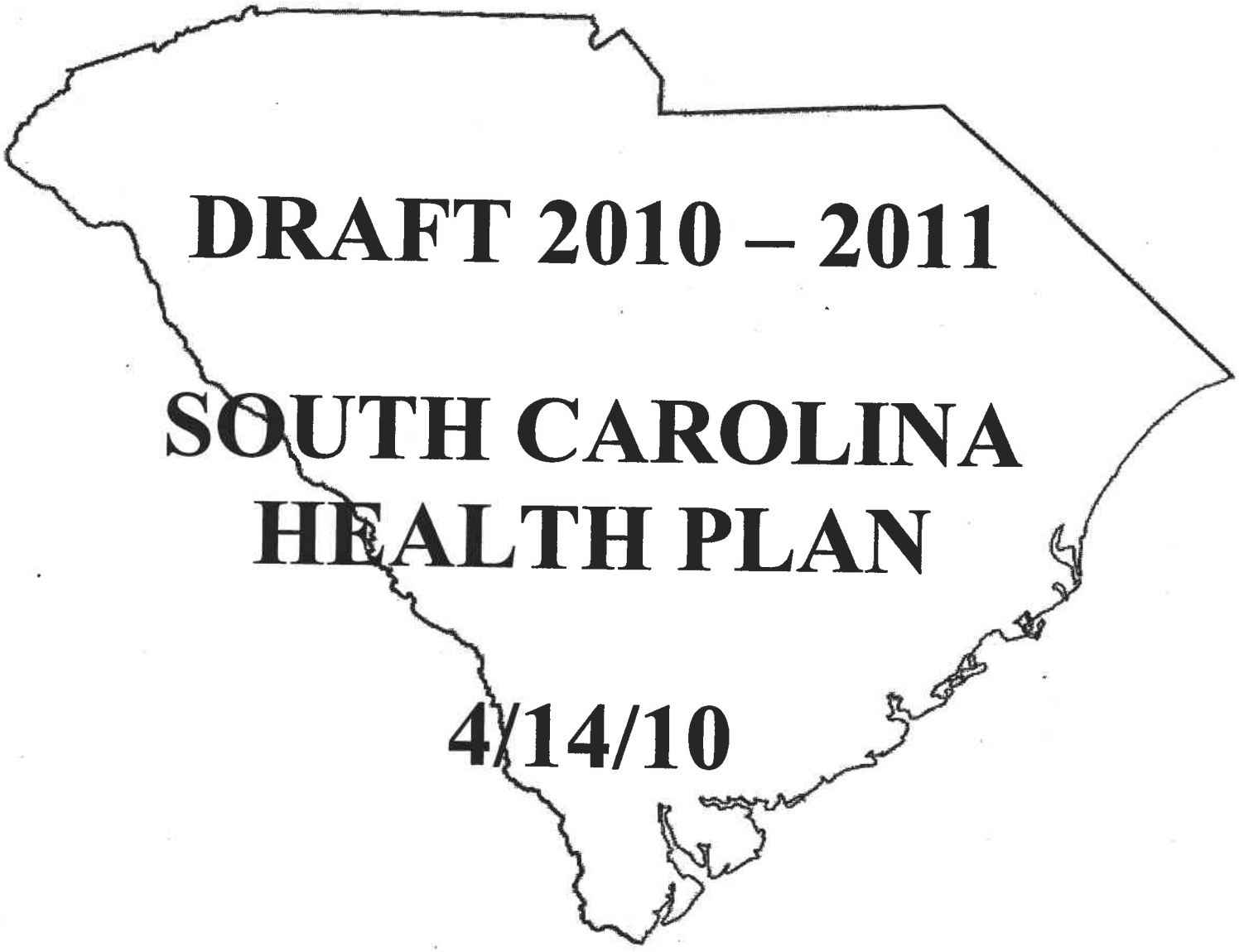
South Carolina Department of Health
and Environmental Control



DRAFT 2010 – 2011

SOUTH CAROLINA HEALTH PLAN

4/14/10

SOUTH CAROLINA STATE HEALTH PLANNING COMMITTEE

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Charles D. Lindley	Consumer
Edward D. Tinsley, III	Consumer
Elliott F. Elam, Jr.	Consumer Affairs Representative (Ex-Officio)
Coleman F. Buckhouse, M.D.	DHEC Board Representative

All correspondence should be addressed to:

State Health Planning Committee
Division of Planning & Certification of Need
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CHAPTER I

INTRODUCTION

A. Legal Basis:

Section 44-7-180 of the South Carolina Code of Laws requires the Department of Health and Environmental Control, with the advice of the S.C. State Health Planning Committee, to prepare a State Health Plan for use in the administration of the Certificate of Need Program.

B. Purpose:

The South Carolina Health Plan outlines the need for medical facilities and services in the State. This document is used as one of the criteria for reviewing projects under the Certificate of Need Program.

C. Health Planning Committee:

This committee is composed of fourteen members. Twelve are appointed by the Governor with at least one member from each congressional district. Health care consumers, health care financiers, including business and insurance, and health care providers are equally represented. One member is appointed by the Chairman of the Board of Health and Environmental Control and the State Consumer Advocate is an ex-officio member. The State Health Planning Committee will review the South Carolina Health Plan and submit it to the Board of Health and Environmental Control for final revision and adoption.

D. Relationship With Other Agencies:

The Department has received consultation and advice from a number of State Agencies, including the Department of Mental Health, Department of Disabilities and Special Needs, Vocational Rehabilitation Department, Department of Social Services, Department of Alcohol and Other Drug Abuse Services, Continuum of Care for Emotionally Disturbed Children, and the Department of Health and Human Services, during the development of this plan including the collection and analysis of data. Other organizations affected under the program, such as the S.C. Hospital Association, the S.C. Home Care Association and the S.C. Health Care Association, have been consulted as the need arises. The Department wishes to express its appreciation for their assistance.

The Department is aware that the ultimate responsibility for administering this program cannot be shared with any individual or organization; however, it does recognize the valuable contributions that can be made by other interested organizations and individuals. For that reason it will be the policy to actively seek cooperation and guidance from anyone who wishes to comment on this plan.

E. Standards of Construction and Equipment:

Construction of health care facilities will comply with the Standards for Licensing as promulgated by the S.C. Department of Health and Environmental Control.

F. Standards for Maintenance and Operation:

Pursuant to the "State Certification of Need and Health Facility Licensure Act," the Division of Health Licensing within the Department of Health and Environmental Control (DHEC) is designated as the responsible agency for the administration and enforcement of basic standards for maintenance and operation of health care facilities and services in South Carolina.

G. State Certification of Need and Health Facility Licensure Act:

1. The purpose of the State Certification of Need and Health Facility Licensure Act, as amended, is to promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services that will best serve public needs, and ensure that high quality services are provided in health facilities in this State.

2. This law requires the:

   (a) issuance of a Certificate of Need prior to the undertaking of any project prescribed by this article;

   (b) adoption of procedures and criteria for submittal of an application and appropriate review prior to issuance of a Certificate of Need;

   (c) preparation and publication of a State Health Plan, with the advice of the health planning committee; and

   (d) licensure of facilities rendering medical, nursing and other health care.

3. An applicant desiring a Certificate of Need for a health-related facility or service or any specific or general information pertaining to the law or its application may contact the Bureau of Health Facilities and Services Development, DHEC, at their mailing address: 2600 Bull Street, Columbia, South Carolina, 29201. The telephone number is (803) 545-4200; fax number is (803) 545-4579.

4. A copy of S.C. Department of Health and Environmental Control Regulation No. 61-15, Certification of Need for Health Facilities and Services, may be obtained from the above address, or accessed on the internet through www.scdhec.net.

H. Relative Importance of Project Review Criteria:

A general statement has been added to each section of Chapter II stating the project review criteria considered to be the most important in reviewing certificate of need applications for each type of facility, service, and equipment. These criteria are not listed in order of importance, but sequentially, as found in Chapter 8 of Regulation No. 61-15, Certification of Need for Health Facilities and Services. In addition, a finding has been made in each section as to whether the benefits of improved accessibility to each such type of facility, service and equipment may outweigh the adverse effects caused by the duplication of any existing facility, service or equipment.

I. Interpretation of the Plan:

The criteria and standards set forth in the Plan speak for themselves, and each section of the Plan must be read as a whole.

J. Quality of Patient Care:

There is both local and national interest regarding the quality of care in the delivery of health care services. The Department of Health and Environmental Control shares these concerns. Organizations such as the Centers for Medicare and Medicaid Services (CMS), The Joint Commission (TJC) and the Leapfrog Group have focused attention upon both patient safety and outcomes. These include the reduction of medical errors, decreasing the risk of health care-acquired infections, and the following of best practices for patient care.

During the development of the current Plan, staff has reviewed the availability of data and quality standards for the types of beds and services referenced in the Plan. To the extent practicable, we have addressed quality standards in those sections of the Plan where we were comfortable that they were appropriate. However, we were not always able to identify standards that could be considered directly applicable for a bed or service in the Plan.

Therefore, where no standards are listed, an applicant may be requested to provide data from sources such as mySChospitals.com, hospitalcompare.hhs.gov, or leapfroggroup.org, to document how its quality of care compares to state, regional, or national averages.

K. Staffing Standards:

During the development of the 2008-09 South Carolina Health Plan, the Planning Committee was requested to undertake a study to determine how best to incorporate nursing and technical staffing information into future Plans. We agreed to undertake such a study; however, we do not have the manpower or technical expertise to conduct this research single-handedly. Staff is currently participating on the Steering Committee for the Office of Healthcare Workforce Research for Nursing (OHWRN), which has a four-year Duke Endowment grant to develop a supply/demand forecast model for nursing (as part of a larger effort that includes also includes allied technical staff).

At this time we are working to obtain the baseline numbers for the current number and type of staff (RNs, EKG Techs, Physical Therapists, etc) by sector (hospitals, nursing homes, ASFs, etc). It is anticipated that we will not have this data available until sometime in 2010. The research will also involve getting health care facilities to project their future needs for additional staff, through both currently budgeted vacancies and planned new projects. We will also have to determine what, if any, staffing guidelines or requirements exist for the various health professions. Only when we have this information available can we attempt to create standards tying staffing requirements to sections in the Plan. Therefore, at this point, we do not have reliable staffing requirements that would be appropriate as CON standards in the Plan.

More information on the OHWRN study can be found at:

http://sc.edu/nursing/workforce/workforce.html

CHAPTER II

PLANNING REGIONS AND FACILITY CATEGORIES

A. Inventory Regions and Service Areas:

This State Plan has adopted four regions and one statewide category for the purpose of inventorying health facilities and services as specified in Section C. below. These regions, based on existing geographic, trade and political areas, are a practical method of administration.

The need for hospital beds is based on the utilization of individual facilities. Nursing home and home health service needs are projected by county. The need for acute psychiatric services, alcohol and drug abuse services, comprehensive rehabilitation services, and residential treatment centers for children and adolescents is based on various service areas and utilization methodologies specified herein. Institutions serving a restricted population throughout the state are planned on a statewide basis. The need for most services (cardiac catheterization, open heart surgery, etc.) is based upon the service standard, which is a combination of utilization criteria and travel time requirements. Each service standard constitutes the service area for that particular service.

Any service area may cross multiple administrative, geographic, trade and/or political boundaries. Due to factors that may include availability, accessibility, personal or physician preferences, insurance and managed care contracts or coverage, or other reimbursement issues, patients may seek and receive treatment outside the county or inventory region in which they reside and/or outside of the state. Therefore, service areas may specifically cross inventory regions and/or state boundaries. The need for a service is analyzed by an assessment of existing resources and need in the relevant service area, along with other factors set forth in this Plan and applicable statutes and regulations.

B. Exceptions to Service Area Standards:

The health care delivery system is in a state of evolution both nationally and in South Carolina. Due to the health reform movement, a number of health care facilities are consolidating and establishing provider networks in order to better compete for contracts within the new environment. This is particularly important for the smaller, more rural facilities that run the risk of being bypassed by insurers and health care purchasers looking for the availability of comprehensive health care services for their subscribers.

Given the changing nature of the health care delivery system, affiliated hospitals may sometimes want to transfer or exchange specific technologies in order to better meet an identified need. Affiliated hospitals are defined as two or more health care facilities, whether inpatient or outpatient, owned, leased, sponsored, or who have a formal legal relationship with a central organization and whose relationship has been established for reasons other than for transferring beds, equipment or services. In certain instances such a transfer or exchange of acute services could be accomplished in a cost-effective manner and result in a more efficient allocation of health care resources. This transfer or exchange of services applies to both inpatient and outpatient services; however, such

transfers or exchanges could only occur between facilities within the same licensing category. A Certificate of Need would be required to achieve the transfer or exchange of services. In order to evaluate a proposal for the transfer or exchange of any health care technology reviewed under the Certificate of Need program, the following criteria must be applied to it:

(1) A transfer or exchange of services may be approved only if there is no overall increase in the number or amount of such services;

(2) Although such transfers may cross county or service area lines, the facilities must be located within the one-way driving time established for the proposed service of each other, as determined by the Department;

(3) The facility receiving the service must demonstrate the need for the additional capacity based on both historical and projected utilization patterns;

(4) The applicants must explain the impact of transferring the technology on the health care delivery system of the county and/or service area from which it is to be taken; any negative impact must be detailed, along with the perceived benefits of the proposal;

(5) The facility giving up the service may not use the loss of such services as justification for a subsequent request for the approval of establishment of such service;

(6) A written contract or agreement between the governing bodies of the affected facilities approving the transfer or exchange of services must be included in the Certificate of Need process;

(7) Each facility giving up a service must acknowledge in writing that this exchange is permanent; any further transfers would be subject to this same process.

C. Identification of Inventory Regions:

The inventory regions are designated as follows:

Region	Counties
I	Anderson, Cherokee, Greenville, Oconee, Pickens, Spartanburg, and Union.
II	Abbeville, Chester, Edgefield, Fairfield, Greenwood, Kershaw, Lancaster, Laurens, Lexington, McCormick, Newberry, Richland, Saluda and York.
III	Chesterfield, Clarendon, Darlington, Dillon, Florence, Georgetown, Horry, Lee, Marion, Marlboro, Sumter and Williamsburg.

IV Aiken, Allendale, Bamberg, Barnwell, Beaufort, Berkeley, Calhoun, Charleston, Colleton, Dorchester, Hampton, Jasper and Orangeburg.

D. Estimated State Civilian Population:

Where these projections were required for calculations, this Plan has been developed using the estimated civilian population of 4,355,080 for 2008 and projected population of 4,674,080 for 2015. All population data (county, planning area, and statewide) were computed by the State Budget and Control Board, Division of Research and Statistical Services, in cooperation with the U.S. Bureau of Census. The Governor has designated the above agency as the official source of all population data to be used by state agencies.

E. Patient Statistics:

Patient statistics in the Plan are based on the 2008 Fiscal Year for health care facilities.

F. Facility Information and Plan Cut-Off Date:

Only those facilities reviewed under the Certificate of Need program are included in the inventory. The cut-off date for inclusion of information in this Plan was April 20, 2010.

CHAPTER III

ACUTE CARE HOSPITALS

A. General Hospitals:

1. Definitions:

"Hospital" means a facility organized and administered to provide overnight medical or surgical care or nursing care of illness, injury, or infirmity and may provide obstetrical care, and in which all diagnoses, treatment, or care is administered by or under the direction of persons currently licensed to practice medicine, surgery, or osteopathy.

"Hospital bed" means a bed for an adult or child patient. Bassinets for the newborn in a maternity unit nursery, beds in labor rooms, recovery rooms, and other beds used exclusively for emergency purposes are not included in this definition.

2. Bed Capacity:

(a) For existing beds, capacity is considered bed space designated exclusively for inpatient care, including space originally designed or remodeled for inpatient beds, even though temporarily not used for such purposes. The number of beds counted in any patient room is the maximum number for which adequate square footage is provided, except that single beds in single rooms have been counted even if the room contained inadequate square footage.

Adequate square footage is defined as:

100 square feet in single rooms;
80 square feet per bed or pediatric crib in multi-bed rooms;
40 square feet per bassinet in pediatric nurseries.

In measuring the square footage of patient rooms for the purpose of determining bed capacity, only the net usable space in the room was considered. Space in toilet rooms, washrooms, closets, vestibules, and corridors was not included.

(b) For facilities constructed under the Certificate of Need program, bed capacity will be as stated in the certificate, regardless of oversize room construction.

(c) For Areas Included:

1. Bed space in <u>all</u> nursing units, including: (1) intensive care unit and (2) minimal or self-care units.
2. Isolation units.
3. Pediatric units, including: (1) pediatric bassinets and (2) incubators located in the pediatric department.

department.

4. Observation units equipped and staffed for overnight use.
5. All space designated for inpatient bed care, even if currently closed or assigned to easily convertible, non-patient uses such as administration offices or storage.
6. Space in areas originally designed as solaria, waiting rooms, offices, conference rooms and classrooms that have necessary fixed equipment and are accessible to a nurses station exclusively staffed for inpatient care.
7. Bed space under construction if planned for immediate completion (not an unfinished "shell" floor).

(d) For Areas Excluded:

1. Newborn nurseries in maternity department.
2. Labor rooms.
3. Recovery rooms.
4. Emergency units.
5. Preparation or anesthesia induction rooms.
6. Rooms used for diagnostic or treatment procedures unless originally designed for patient care.
7. Hospital staff bed areas, including accommodations for on-call staff unless originally designed for patient care.
8. Corridors.
9. Solaria, waiting rooms and other areas that not permanently set aside, equipped and staffed exclusively for inpatient bed care.
10. Unfinished space (shell) [an area that is finished except for movable equipment shall not be considered unfinished space].
11. Psychiatric, substance abuse and comprehensive rehabilitation units of general hospitals are separate categories of bed utilizing the same criteria outlined for general acute beds.

3. Inventory:

(a) All licensed general hospitals, including Federal facilities, are listed in the inventory. Patient days and admissions are as reported by the hospital. The number of patient days utilized for the general hospital bed need calculations does not include days of care rendered in licensed psychiatric units, substance abuse units, or comprehensive rehabilitation units of hospitals. These days of care are shown in the corresponding inventories for each type of service. In addition, the days of care provided in Long-Term Care hospitals are not included in the general bed need calculations.

(b) Total capacity by survey refers to a total designed capacity or maximum number of beds that may be accommodated as determined by an on-site survey. This capacity may exceed the number of beds actually set up and in use. It may also differ from the licensed capacity, which is based on State laws and regulations. Beds have been classified as conforming and nonconforming, according to standards of plant evaluation, such as:

which is based on State laws and regulations. Beds have been classified as conforming and nonconforming, according to standards of plant evaluation, such as:

1. Fire-resistivity of each building.
2. Fire and other safety factors of each building.
3. Design and structural factors affecting the function of nursing units.
4. Design and structural factors affecting the function of service departments.

4. Narrative: General Hospital Beds:

The General Acute Hospital bed need methodology uses the following variable occupancy rate factors:

0-174 bed hospitals, 65%;
175-349 bed hospitals, 70%; and
350+ bed hospitals, 75%.

The population and associated utilization are broken down by age groups. The use rates and projected average daily census are made for the age cohorts of 0-17, 18-64, and 65 and over, recognizing that different population groups have different hospital utilization rates. For some hospitals, different age groups were used based on the data provided by the facility.

Where the term "hospital bed need" is used, these figures are based upon utilization data for the general acute hospitals. This term does not suggest that facilities cannot operate at higher occupancy rates than used in the calculations without adding additional beds.

The methodology for calculating bed need is as follows:

(a) Calculations of bed need are made for individual hospitals, because of the differing occupancy factors used for individual facilities, and then summed by county to get the overall county bed need.

(b) Compute the need:

1. Multiply the current facility use rate by age cohort by the projected population by age cohort (in thousands) and divide by 365 to obtain a projected average daily census by age cohort.

2. Divide the sum of the age cohort projected facility average daily census by the variable occupancy (.65/.70/.75) to determine the number of beds needed to meet the area's need.

(c) The number of additional beds needed or excess beds is obtained by subtracting the number of existing beds from the bed need.

(d) If a county indicates a surplus of beds, then no additional beds will be approved unless an individual hospital in the county indicates a need for additional beds. Should an individual hospital indicate a need for additional beds, then a maximum of the actual projected bed need or up to 50 additional beds may be approved for that hospital to allow for the construction of an economical unit at either the existing hospital site or another site, if the existing hospital is relocating or has relocated in whole or in part to that site. The hospital requesting the addition must document the need for additional beds beyond those indicated as needed by the methodology stated above, based on historical and projected utilization, as well as projected population growth or other factors demonstrating the need for the proposed beds. Additional beds will only be approved for the specific hospital indicating a need.

(e) If there is a need for additional hospital beds in the county, then any entity may apply to add these beds within the county, and any entity may be awarded the Certificate of Need for these beds. If the number of beds needed is less than 50, then up to a total of 50 beds could be approved for any entity at any location within the county. An applicant requesting additional beds beyond those indicated as needed by the methodology stated above, must document the need for additional beds based on historical and projected utilization, floor plan layouts, projected population growth that has not been considered in this Plan or other factors demonstrating the need for the proposed beds. It is up to the applicant to document the need and the potential negative impact on the existing facilities.

(f) No additional hospitals will be approved unless they are a general hospital and will provide:

1. A 24-hour emergency services department, and meet the requirements to be a Level III emergency service as defined in Regulation 61-16 Sec. 613 Emergency Services.

2. Inpatient medical services to both surgical and non-surgical patients, and

3. Medical and surgical services on a daily basis within at least 6 of the major diagnostic categories as recognized by Centers for Medicare and Medicaid Services (CMS), as follows:

MDC 1: Diseases and disorders of the nervous system
MDC 2: Diseases and disorders of the eye
MDC 3: Diseases and disorders of the ear, nose, mouth and throat
MDC 4: Diseases and disorders of the respiratory system
MDC 5: Diseases and disorders of the circulatory system
MDC 6: Diseases and disorders of the digestive system
MDC 7: Diseases and disorders of the hepatobiliary system and pancreas
MDC 8: Diseases and disorders of the musculoskeletal system and connective tissue
MDC 9: Diseases and disorders of the skin, subcutaneous tissue and breast
MDC 10: Endocrine, nutritional and metabolic diseases and disorders
MDC 11: Diseases and disorders of the kidney and urinary tract
MDC 12: Diseases and disorders of the male reproductive system
MDC 13: Diseases and disorders of the female reproductive system

MDC 14: Pregnancy, childbirth and the puerperium
MDC 15: Newborns/other neonates with conditions originating in the prenatal period
MDC 16: Diseases and disorders of the blood and blood-forming organs and immunological disorders
MDC17: Myeloproliferative diseases and disorders and poorly differentiated neoplasms
MDC 18: Infectious and parasitic diseases
MDC 19: Mental diseases and disorders
MDC20: Alcohol/drug use and alcohol/drug-induced organic mental disorders
MDC 21: Injury, poisoning and toxic effects of drugs
MDC 22: Burns
MDC 23: Factors influencing health status and other contact with health services
MDC 24: Multiple significant traumas
MDC 25: Human immunodeficiency virus infections

Any applicant for a new hospital must provide a written commitment that the facility will accept Medicare and Medicaid patients and that un-reimbursed services for indigent and charity patients are provided at a percentage which meets or exceeds other hospitals in the service area.

(g) In some areas of South Carolina, a considerable influx of tourists is not counted in the permanent population. If an individual hospital in these areas can document and demonstrate the need for additional beds due to non-resident (tourist) population and seasonal utilization fluctuations due to this population, then, based on further analysis, the Department may approve some additional beds at the existing hospital.

(h) Should a hospital request additional beds due to the deletion of services at a Federal facility that results in the immediate impact on the utilization of the hospital, then additional beds may be approved at the affected hospital. The impacted hospital must document this increase in demand and explain why additional beds are needed to accommodate the care of patients previously served at a Federal facility. Based on the analysis of utilization provided by the affected hospital, the Department may approve some additional hospital beds to accommodate this immediate need.

(i) Due to the low utilization and the low capital cost of converting hospital-based nursing home, psychiatric and/or substance abuse beds to general acute care hospital beds, the following policies may apply:

1. Hospitals that have licensed nursing home beds within the hospital may be allowed to convert these nursing home beds to acute care hospital beds only within the hospital provided the hospital can document an actual need for these additional acute care beds. Need will be based on actual utilization, using current information. A CON is required for this conversion.

2. Existing general hospitals that have inpatient psychiatric, rehabilitation, or substance abuse beds may be allowed to convert these specialty beds to acute care hospital beds, regardless of the projected need for general acute care hospital beds, provided a Certificate of Need is received.

(j) Changes in the delivery system due to health care reform have resulted in the consolidation of facilities and the establishment of provider networks. These consolidations and agreements may lead to situations where affiliated hospitals may wish to transfer beds between themselves in order to serve their patients in a more efficient manner. A proposal to transfer or exchange hospital beds requires a Certificate of Need and must comply with the following criteria:

1. A transfer or exchange of beds may be approved only if there is no overall increase in the number of beds;

2. Such transfers may cross county lines; however, the applicants must document with patient origin data the historical utilization of the receiving facility by residents of the county giving up beds;

3. Should the response to Criterion 2 fail to show a historical precedence of residents of the county transferring the beds utilizing the receiving facility, the applicants must document why it is in the best interest of these residents to transfer the beds to a facility with no historical affinity for them;

4. The applicants must explain the impact of transferring the beds on the health care delivery system of the county from which the beds are to be taken; any negative impact must be detailed, along with the perceived benefits of such an agreement;

5. The facility receiving the beds must demonstrate the need for the additional capacity based on both historical and projected utilization patterns;

6. The facility giving up the beds may not use the loss of these beds as justification for a subsequent request for the approval of additional beds;

7. A written contract or agreement between the governing bodies of the affected facilities approving the transfer or exchange of beds must be included in the Certificate of Need application;

8. Each facility giving up beds must acknowledge in writing that this exchange is permanent; any further transfers would be subject to this same process.

(k) Factors to be considered regarding modernization of facilities should include:

1. Functional arrangement of the facility as it relates to efficient handling of patients and related workloads.
2. The ability to update medical technology within the existing plant.
3. Existence of The Joint Commission (TJC) deficiencies or "grandfathered" licensure deficiencies.
4. Cost efficiency of the existing physical plant versus plant revision, etc.
5. Private rooms are now considered the industry standard.

(l) Each modernization proposal must be evaluated on the basis of merit, cost efficiency, and impact on health delivery and status within the service area.

Quality

A number of quality indicators have been identified for hospitals by organizations such as CMS (Hospital Compare), the Agency for Healthcare Research and Quality (AHRQ), and the Commonwealth Fund (Why Not the Best?). Data for these measures are accessible on-line, and it is possible to compare how hospitals rate on these various measures. They can also be compared against similar facilities (i.e. teaching hospitals) and against state and/or national averages.

Unfortunately, because each organization categorizes its data differently, these indicators can only be discussed in generalities. They can be roughly divided into four categories. The first measurements are what CMS calls Hospital Process of Care measures. These capture how often hospitals perform the recommended processes for different diagnoses. For example, do the hospitals give heart attack patients aspirin when they arrive at the hospital and smoking cessation advice/counseling before they're discharged? Are surgical patients receiving the right antibiotics prior to surgery to prevent infections or the right treatment to prevent blood clots? Source:
http://www.hospitalcompare.hhs.gov/Hospital/Static/ConsumerInformation

The second type of indicators are what AHRQ calls Patient Safety Indicators (PSIs). These are indicators on potential preventable in-hospital adverse events and complications following surgery, childbirth, and other procedures. They include anesthesia complications, decubitus ulcers, leaving foreign bodies in after surgery, post-operative infections, transfusion reactions, and birth trauma. Source:
http://www.qualityindicators.ahrq.gov/downloads/psi/2006-Feb-PatientSafetyIndicators.pdf

A sub-set of patient safety indicators is DHEC's Hospital Acquired Infections (HAI) report. It lists the actual and expected rates of Surgical Site Infections (SSIs) for various types of surgeries (coronary bypass, gallbladder removal, hysterectomy, knee replacement, etc.) and Central Line Associated Blood Stream Infection (CLABSI) rates for hospitals. Source:
http://www.scdhec.gov/health/disease/hai/reports.htm

Next are Inpatient Quality Indicators (IQIs). These include volume (where there has been a link determined between the number of procedures performed and an outcome such as mortality), in-

house mortality (examines outcomes following procedures and for common medical conditions), and utilization (where questions have been raised about over-use or under-use of a procedure). Examples include in-house mortality from hip replacements, GI hemorrhages, strokes, and pneumonia, and the volume of open heart surgeries and cesarean sections performed. Source: http://www.qualityindicators.ahrq.gov/downloads/iqi/iqi_guide_v31.pdf

The final indicator is Patient Satisfaction. A patient's perceptions of the care received during a hospital stay impacts how the patient views the outcome of the stay. The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey was developed by CMS and AHRQ to collect patient feedback. It asks whether nurses were readily available when called, procedures were adequately explained before they were performed, the room was kept clean, it was quiet at night, etc. As part of these surveys, patients rate their overall satisfaction with the facility (0-10) and whether they would recommend the hospital to others. Perceptions of poor patient care can hurt a hospital, even if the outcomes were satisfactory. Source: http://www.hospitalcompare.hhs.gov/Hospital/Static/ConsumerInformation

Starting in June 2010, Hospital Compare will report outpatient quality measures related to heart attack and chest pain treatment, outpatient surgery safety, and imaging equipment efficiency. Hospitals that don't comply with the quality data reporting requirements face a 2% reduction in their reimbursements. Source: http://www.cms.hhs.gov/HospitalQualityInits/34_HospitalOutpatientMeasures.asp

Hospitals should have high compliance rates for the procedures that have been identified as improving the quality of care or reducing the risks of complications. Infection rates should be below or comparable to the expected numbers.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating certificate of need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Acceptability;
e. Financial Feasibility;
f. Cost Containment; and
g. Adverse Effects on Other Facilities.

General hospital beds are located within approximately thirty (30) minutes travel time for the majority of the residents of the State, and current utilization and population growth are factored into the methodology for determining general hospital beds. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for these beds.

2015 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2008 POP	2015 POP	2008 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
REGION I									
ANMED HEALTH MEDICAL CENTER	<18	42,580	43,680	2,078	6				
	18-64	109,630	115,700	41,043	119				
	+65	24,840	29,040	34,961	112				
	TOTAL	177,050	188,420	78,082	236	0.75	316	423	-107
ANMED WOMEN'S & CHILDRENS HOSPITAL	<18	42,580	43,680	241	1				
	18-64	109,630	115,700	4,769	14				
	+65	24,840	29,040	3,870	12				
	TOTAL	177,050	188,420	8,880	27	0.65	42	72	-30
ANDERSON COUNTY TOTAL							**358**	**495**	**-137**
UPSTATE CAROLINA MEDICAL CENTER	<18	14,550	15,220	682	2				
	18-64	35,180	37,750	7,164	21				
	+65	6,880	7,960	7,676	24				
	TOTAL	56,610	60,930	15,522	47	0.65	73	125	-52
CHEROKEE COUNTY TOTAL							**73**	**125**	**-52**
GREENVILLE MEMORIAL MEDICAL CENTER	<18	98,820	101,730	19,594	55				
	18-64	264,740	286,170	118,620	351				
	+65	48,160	56,980	44,091	143				
	TOTAL	411,720	444,880	138,214	549	0.75	733	746	-13
GREER MEMORIAL HOSPITAL	<18	98,820	101,730	161	0				
	18-64	264,740	286,170	6,963	21				
	+65	48,160	56,980	3,973	13				
	TOTAL	411,720	444,880	7,124	34	0.65	52	82	-30
HILLCREST MEMORIAL HOSPITAL	<18	98,820	101,730	10	0				
	18-64	264,740	286,170	4,679	14				
	+65	48,160	56,980	3,277	11				
	TOTAL	411,720	444,880	7,966	25	0.65	38	43	-5
PATEWOOD MEMORIAL HOSPITAL	<18	98,820	101,730	6	0				
	18-64	264,740	286,170	1,658	5				
	+65	48,160	56,980	1,159	4				
	TOTAL	411,720	444,880	2,823	9	0.65	13	72	-59
SAINT FRANCIS - DOWNTOWN	<18	98,820	101,730	447	1				
	18-64	264,740	286,170	28,178	83				
	+65	48,160	56,980	35,674	116				
	TOTAL	411,720	444,880	64,299	200	0.70	286	226	60
SAINT FRANCIS - EASTSIDE	<18	98,820	101,730	226	1				
	18-64	264,740	286,170	14,269	42				
	+65	48,160	56,980	4,730	15				
	TOTAL	411,720	444,880	19,225	58	0.65	90	93	-3
GREENVILLE COUNTY TOTAL							**1,212**	**1,262**	**-50**

2015 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2008 POP	2015 POP	2008 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
OCONEE MEMORIAL HOSPITAL	<18	15,780	16,090	699	2				
	18-64	44,280	46,750	15,040	44				
	+65	13,590	17,190	10,492	36				
	TOTAL	73,650	80,030	26,231	82	0.65	126	169	-43
OCONEE COUNTY TOTAL							**126**	**169**	**-43**
CANNON MEMORIAL HOSPITAL	<18	28,870	30,460	15	0				
	18-64	80,630	87,500	1,413	4				
	+65	14,360	17,230	2,343	8				
	TOTAL	123,860	135,190	3,771	12	0.65	18	55	-37
PALMETTO BAPTIST MED CTR EASLEY	<18	28,870	30,460	401	1				
	18-64	80,630	87,500	7,887	23				
	+65	14,360	17,230	12,236	40				
	TOTAL	123,860	135,190	20,524	65	0.65	100	109	-9
PICKENS COUNTY TOTAL							**118**	**164**	**-46**
MARY BLACK MEMORIAL	<18	66,990	68,180	1,362	4				
	18-64	174,060	184,850	19,871	58				
	+65	34,240	40,790	7,304	24				
	TOTAL	275,290	293,820	28,537	85	0.70	122	176	-54
SPARTANBURG REG MED CTR & VILLAGE HEALTH CENTRE *1*	<18	66,990	68,180	3,874	11				
	18-64	174,060	184,850	71,257	207				
	+65	34,240	40,790	64,063	209				
	TOTAL	275,290	293,820	139,194	427	0.75	570	532	38
SPARTANBURG COUNTY TOTAL							**692**	**708**	**-16**
WALLACE THOMSON HOSPITAL	<18	7,040	6,910	354	1				
	18-64	17,640	16,920	4,555	12				
	+65	4,930	5,420	6,147	19				
	TOTAL	29,610	29,250	11,055	31	0.65	48	143	-95
UNION COUNTY TOTAL							**48**	**143**	**-95**
REGION II									
ABBEVILLE AREA MEDICAL CENTER	<18	6,750	6,860	138	0				
	18-64	16,450	17,040	1,241	4				
	+65	4,020	4,580	1,944	6				
	TOTAL	27,220	28,480	3,323	10	0.65	15	25	-10
ABBEVILLE COUNTY TOTAL							**15**	**25**	**-10**

2015 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2008 POP	2015 POP	2008 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
CHESTER REGIONAL MEDICAL CENTER	<18	8,990	6,040	419	1				
	18-64	21,550	22,040	3,079	9				
	+65	4,600	5,310	3,815	12				
	TOTAL	35,140	33,390	7,313	21	0.65	33	82	-49
CHESTER COUNTY TOTAL							**33**	**82**	**-49**
EDGEFIELD COUNTY HOSPITAL	<18	5,820	5,840	57	0				
	18-64	17,730	19,430	478	1				
	+65	3,040	4,050	1,440	5				
	TOTAL	26,590	29,320	1,975	7	0.65	11	25	-14
EDGEFIELD COUNTY TOTAL							**11**	**25**	**-14**
FAIRFIELD MEMORIAL HOSPITAL	<18	6,200	6,160	51	0				
	18-64	15,340	15,570	1,532	4				
	+65	3,190	4,040	1,576	5				
	TOTAL	24,730	25,770	3,158	10	0.65	15	25	-10
FAIRFIELD COUNTY TOTAL							**15**	**25**	**-10**
SELF REGIONAL HEALTHCARE	<18	17,790	18,170	1,760	5				
	18-64	42,930	44,790	25,472	73				
	+65	9,400	10,720	26,524	83				
	TOTAL	70,120	73,680	53,756	161	0.75	214	354	-140
GREENWOOD COUNTY TOTAL							**214**	**354**	**-140**
KERSHAW HEALTH	<18	14,050	14,600	1,122	3				
	18-64	35,840	38,730	10,561	31				
	+65	7,570	9,160	15,678	52				
	TOTAL	57,460	62,490	27,361	86	0.65	133	121	12
KERSHAW COUNTY TOTAL							**133**	**121**	**12**
SPRINGS MEMORIAL HOSPITAL	<18	15,490	15,450	1,006	3				
	18-64	39,960	41,380	13,442	38				
	+65	7,700	9,100	16,491	53				
	TOTAL	63,150	65,930	30,939	94	0.70	135	217	-82
LANCASTER COUNTY TOTAL							**135**	**217**	**-82**
LAURENS COUNTY HOSPITAL	<18	17,720	17,690	237	1				
	18-64	47,420	51,410	5,431	16				
	+65	10,310	12,460	6,761	22				
	TOTAL	75,450	81,560	12,429	39	0.65	60	76	-16
LAURENS COUNTY TOTAL							**60**	**76**	**-16**

2015 HOSPITAL BED NEED

FACILITY/COUNTY		AGE CAT	2008 POP	2015 POP	2008 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
LEXINGTON MEDICAL CENTER		<18	40,795	42,156	1,363	4				
		18-64	109,617	120,260	52,458	158				
		+65	42,746	52,791	43,932	149				
		TOTAL	193,158	215,207	97,753	310	0.75	414	414	0
LEXINGTON COUNTY TOTAL								**414**	**414**	**0**
NEWBERRY COUNTY MEMORIAL		<18	8,970	9,090	301	1				
		18-64	23,470	23,990	4,097	11				
		+65	5,590	6,690	6,379	21				
		TOTAL	38,030	39,770	10,777	33	0.65	51	90	-39
NEWBERRY COUNTY TOTAL								**51**	**90**	**-39**
PALMETTO HEALTH BAPTIST & PALMETTO HEALTH PARKRIDGE	2	<18	101,035	103,794	1,392	4				
		18-64	272,173	287,940	50,840	147				
		+65	53,154	68,539	16,537	58				
		TOTAL	426,362	460,273	68,769	210	0.75	280	363	-83
PALMETTO HEALTH RICHLAND		<18	101,035	103,794	24,030	68				
		18-64	272,173	287,940	96,286	279				
		+65	53,154	68,539	39,544	140				
		TOTAL	426,362	460,273	159,860	486	0.75	649	579	70
PROVIDENCE HOSPITAL		<18	101,035	103,794	46	0				
		18-64	272,173	287,940	23,450	68				
		+65	53,154	68,539	31,810	112				
		TOTAL	426,362	460,273	55,306	180	0.70	258	258	0
PROVIDENCE HOSPITAL NORTHEAST		<18	101,035	103,794	12	0				
		18-64	272,173	287,940	6,134	18				
		+65	53,154	68,539	4,114	15				
		TOTAL	426,362	460,273	10,260	32	0.65	50	84	-34
RICHLAND COUNTY TOTAL								**1,237**	**1,284**	**-47**
PIEDMONT MEDICAL CENTER & FORT MILL MEDICAL CENTER	3	<18	45,490	46,590	1,906	5				
		18-64	120,910	135,640	31,074	96				
		+65	19,910	24,930	28,449	98				
		TOTAL	186,310	207,160	61,429	198	0.70	283	332	-49
YORK COUNTY TOTAL								**283**	**332**	**-49**
REGION III										
CHESTERFIELD GENERAL HOSPITAL		<18	11,170	11,110	694	2				
		18-64	27,270	27,860	5,627	16				
		+65	5,370	6,520	4,967	17				
		TOTAL	43,810	45,490	11,288	32	0.65	50	59	-9
CHESTERFIELD COUNTY TOTAL								**50**	**59**	**-9**

2015 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2008 POP	2015 POP	2008 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
CLARENDON MEMORIAL HOSPITAL	<18	7,870	7,750	393	1				
	18-64	20,460	20,500	7,980	22				
	+65	5,770	7,700	5,652	21				
	TOTAL	34,100	35,950	14,025	44	0.65	67	56	11
CLARENDON COUNTY							**67**	**56**	**11**
CAROLINA PINES REGIONAL	<18	17,670	17,160	2,168	6				
	18-64	42,370	42,970	22,378	62				
	+65	8,690	10,490	6,323	21				
	TOTAL	68,730	70,620	30,869	89	0.65	137	116	21
MCLEOD MEDICAL CENTER - DARLINGTON	<18	17,670	17,160	3	0				
	18-64	42,370	42,970	6,197	17				
	+65	8,690	10,490	2,653	9				
	TOTAL	68,730	70,620	8,853	26	0.65	40	49	-9
DARLINGTON COUNTY TOTAL							**177**	**165**	**12**
MCLEOD MEDICAL CENTER - DILLON	<18	8,210	7,860	724	2				
	18-64	18,520	18,480	6,221	17				
	+65	3,460	4,010	4,399	14				
	TOTAL	30,190	30,350	11,344	33	0.65	51	79	-28
DILLON COUNTY TOTAL							**51**	**79**	**-28**
CAROLINAS HOSPITAL SYSTEM	<18	32,710	32,850	1,877	5				
	18-64	83,740	85,890	36,345	102				
	+65	16,350	20,110	31,527	106				
	TOTAL	132,800	138,850	69,749	214	0.70	305	310	-5
WOMENS CTR CAROLINAS HOSP SYSTEM	<18	32,710	32,850	178	0				
	18-64	83,740	85,890	3,451	10				
	+65	16,350	20,110	0	0				
	TOTAL	132,800	138,850	3,629	10	0.65	16	20	-4
LAKE CITY COMMUNITY HOSPITAL	<18	32,710	32,850	88	0				
	18-64	83,740	85,890	1,996	6				
	+65	16,350	20,110	1,924	6				
	TOTAL	132,800	138,850	4,008	11	0.65	18	48	-30
MCLEOD REGIONAL MEDICAL CENTER	<18	32,710	32,850	7,476	21				
	18-64	83,740	85,890	61,091	172				
	+65	16,350	20,110	49,471	167				
	TOTAL	132,800	138,850	118,038	359	0.75	479	453	26
FLORENCE COUNTY TOTAL							**818**	**831**	**-13**
GEORGETOWN MEMORIAL HOSPITAL	<18	12,190	12,300	1,204	3				
	18-64	36,120	37,560	10,111	29				
	+65	11,350	15,380	15,246	57				
	TOTAL	59,660	65,240	26,561	89	0.65	137	131	6

2015 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2008 POP	2015 POP	2008 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
WACCAMAW COMMUNITY HOSPITAL	<18	12,190	12,300	408	1				
	18-64	36,120	37,560	8,596	24				
	+65	11,350	15,380	17,081	63				
	TOTAL	59,660	65,240	21,880	89	0.65	137	124	13
GEORGETOWN COUNTY TOTAL							**274**	**255**	**19**
CONWAY HOSPITAL	<18	43,250	44,140	1,333	4				
	18-64	146,530	165,030	20,643	64				
	+65	40,000	53,010	15,431	56				
	TOTAL	229,780	262,180	37,407	123	0.70	177	210	-33
GRAND STRAND REGIONAL MEDICAL CTR	<18	43,250	44,140	929	3				
	18-64	146,530	165,030	24,564	76				
	+65	40,000	53,010	32,791	119				
	TOTAL	229,780	262,180	58,284	197	0.70	282	269	13
LORIS COMMUNITY HOSPITAL & SEACOAST MEDICAL CENTER *4*	<18	43,250	44,140	480	1				
	18-64	146,530	165,030	6,884	21				
	+65	40,000	53,010	7,730	28				
	TOTAL	229,780	262,180	15,094	51	0.65	78	155	-77
HORRY COUNTY TOTAL							**537**	**634**	**-97**
MARION COUNTY MEDICAL CENTER	<18	9,330	9,020	743	2				
	18-64	22,490	22,690	11,820	33				
	+65	4,430	5,130	6,559	21				
	TOTAL	36,250	36,840	19,122	55	0.65	85	124	-39
MARION COUNTY TOTAL							**85**	**124**	**-39**
MARLBORO PARK HOSPITAL	<18	7,190	6,950	194	1				
	18-64	17,250	16,220	3,019	8				
	+65	3,280	3,640	2,095	6				
	TOTAL	27,720	26,810	5,308	15	0.65	23	94	-71
MARLBORO COUNTY TOTAL							**23**	**94**	**-71**
TUOMEY	<18	30,940	31,800	1,588	4				
	18-64	69,480	71,570	33,355	94				
	+65	14,080	16,820	34,114	112				
	TOTAL	114,500	120,190	69,057	210	0.70	301	283	18
SUMTER COUNTY TOTAL							**301**	**283**	**18**
WILLIAMSBURG REGIONAL HOSPITAL	<18	9,670	9,030	85	0				
	18-64	22,100	21,380	554	1				
	+65	5,120	6,290	780	3				
	TOTAL	36,890	36,700	1,419	4	0.65	7	25	-18
WILLIAMSBURG COUNTY TOTAL							**7**	**25**	**-18**

2015 HOSPITAL BED NEED

FACILITY/COUNTY		AGE CAT	2008 POP	2015 POP	2008 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
REGION IV										
AIKEN REGIONAL MEDICAL CENTER		<18	37,770	37,980	636	2				
		18-64	100,180	109,030	20,686	62				
		+65	21,990	27,000	20,129	68				
		TOTAL	159,940	174,010	41,451	131	0.70	187	183	4
AIKEN COUNTY TOTAL								**187**	**183**	**4**
ALLENDALE COUNTY HOSPITAL		<18	3,050	3,040	31	0				
		18-64	7,180	6,990	468	1				
		+65	1,690	2,060	826	3				
		TOTAL	11,920	2,510	1,325	4	0.65	6	25	-19
ALLENDALE COUNTY TOTAL								**6**	**25**	**-19**
BAMBERG COUNTY MEMORIAL HOSP	*5*	<18	3,970	3,680	36	0				
		18-64	9,710	9,070	1,024	3				
		+65	2,220	2,600	1,039	3				
		TOTAL	15,900	15,350	2,098	6	0.65	9	59	-50
BAMBERG COUNTY TOTAL								**9**	**59**	**-50**
BARNWELL COUNTY HOSPITAL		<18	6,180	6,010	121	0				
		18-64	15,430	16,310	1,625	5				
		+65	3,330	4,130	1,914	7				
		TOTAL	24,940	26,450	3,660	12	0.65	18	53	-35
BARNWELL COUNTY TOTAL								**18**	**53**	**-35**
BEAUFORT MEMORIAL HOSPITAL		<18	28,050	26,890	1,424	4				
		18-64	84,600	93,210	18,590	56				
		+65	28,340	40,020	19,539	76				
		TOTAL	140,990	160,120	39,553	135	0.65	209	169	40
HILTON HEAD HOSPITAL		<18	28,050	26,890	196	1				
		18-64	84,600	93,210	7,151	22				
		+65	28,340	40,020	11,347	44				
		TOTAL	140,990	160,120	18,694	66	0.65	102	93	9
BEAUFORT COUNTY TOTAL								**311**	**262**	**49**
TRIDENT MED CENTER & BERKELEY MEDICAL CENTER	*6*	<18	143,400	146,990	1,144	3				
		18-64	383,560	395,320	37,105	105				
		+65	73,200	97,440	33,883	124				
		TOTAL	600,160	639,750	72,132	232	0.70	331	346	-15
SUMMERVILLE MEDICAL CENTER		<18	143,400	146,990	332	1				
		18-64	383,560	395,320	10,754	30				
		+65	73,200	97,440	9,821	36				
		TOTAL	600,160	639,750	20,907	67	0.65	103	94	9

2015 HOSPITAL BED NEED

FACILITY/COUNTY		AGE CAT	2008 POP	2015 POP	2008 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)
CHARLESTON MEMORIAL HOSPITAL	*7*	<18	143,400	146,990	0	0				
		18-64	383,560	395,320	6,166	17				
		+65	73,200	97,440	241	1				
		TOTAL	600,160	639,750	6,407	18	0.65			
MUSC MEDICAL CENTER	*7*	<18	143,400	146,990	2,653	7				
		18-64	383,560	395,320	82,391	233				
		+65	73,200	97,440	29,152	106				
		TOTAL	600,160	639,750	114,196	346	0.75	482	604	-122
ROPER, ROPER ST FRANCIS MT PLEASANT & ROPER ST FRANCIS - BERKELEY	*8*	<18	143,400	146,990	166	0				
		18-64	383,560	395,320	35,960	102				
		+65	73,200	97,440	47,069	172				
		TOTAL	600,160	639,750	83,195	274	0.75	365	401	-36
BON SECOURS ST FRANCIS XAVIER		<18	143,400	146,990	280	1				
		18-64	383,560	395,320	19,514	55				
		+65	73,200	97,440	14,935	54				
		TOTAL	600,160	639,750	34,729	110	0.70	158	204	-46
EAST COOPER REGIONAL MEDICAL CTR		<18	143,400	146,990	90	0				
		18-64	383,560	395,320	11,465	32				
		+65	73,200	97,440	6,471	24				
		TOTAL	600,160	639,750	18,026	56	0.65	87	140	-53
BERKELEY/CHARLESTON/DORCHESTER TOTAL								**1,526**	**1,789**	**-263**
COLLETON MEDICAL CENTER		<18	10,640	10,930	335	1				
		18-64	24,810	25,650	10,110	29				
		+65	5,450	6,690	11,873	40				
		TOTAL	40,900	43,270	22,318	70	0.65	107	131	-24
COLLETON COUNTY TOTAL								**107**	**131**	**-24**
HAMPTON REGIONAL MEDICAL CTR		<18	5,550	5,500	30	0				
		18-64	13,910	14,460	1,889	5				
		+65	2,880	3,600	1,143	4				
		TOTAL	22,340	23,560	3,062	9	0.65	14	32	-18
HAMPTON COUNTY TOTAL								**14**	**32**	**-18**
COASTAL CAROLINA MEDICAL CENTER		<18	5,140	4,910	34	0				
		18-64	14,540	16,250	1,511	5				
		+65	2,670	3,450	2,271	8				
		TOTAL	22,350	24,610	3,816	13	0.65	20	31	-11
JASPER COUNTY TOTAL								**20**	**31**	**-11**
REG MED CTR ORANGEBURG-CALHOUN		<18	23,820	23,820	2,053	6				
		18-64	58,470	59,300	25,424	71				
		+65	13,560	16,370	26,377	87				
		TOTAL	95,850	99,490	53,854	164	0.70	234	247	-13
ORANGEBURG/CALHOUN COUNTY TOTAL								**234**	**247**	**-13**

2015 HOSPITAL BED NEED

FACILITY/COUNTY	AGE CAT	2008 POP	2015 POP	2008 DAYS	PROJ ADC	% OCCU	BED NEED	EXIST BEDS	TO BE ADDED/OR (EXCESS)

1 BED NEEDS COMBINED; THE NEW HOSPITAL WAS CREATED BY TRANSFERRING BEDS FROM THE EXISTING HOSPITAL 9/9/05.
2 BED NEEDS COMBINED; THE NEW HOSPITAL WAS CREATED BY TRANSFERRING BEDS FROM THE EXISTING HOSPITAL; APPEALED.
3 BED NEEDS COMBINED; THE NEW HOSPITAL WAS CREATED BY TRANSFERRING BEDS FROM THE EXISTING HOSPITAL; APPEALED.
4 BED NEEDS COMBINED;THE NEW HOSPITAL WAS CREATED BY TRANSFERRING BEDS FROM THE EXISTING HOSPITAL; APPEALED; CON 9/4/07.
5 USED 2008 ORS DISCHARGE DATA BECAUSE JARS DATA WERE NOT AVAILABLE.
6 BED NEEDS COMBINED;THE NEW HOSPITAL WAS CREATED BY TRANSFERRING BED NEED FROM THE EXISTING HOSPITAL; APPEALED.
7 CON ISSUED TO COMBINE THESE FACILITIES.
8 BED NEEDS COMBINED; MT PLEASANT WAS CREATED BY TRANSFERRING BEDS FROM THE EXISTING HOSPITAL 5/31/06. BERKELEY WAS CREATED BY TRANSFERRING BEDS FROM THE EXISTING HOSPITAL; APPEALED.

HOSPITAL OCCUPANCY RATES

	2006	2007	2008
REGION I	**59.4**	**56.8**	**55.8**
ANMED HEALTH MEDICAL CENTER	52.6	50.9	50.4
ANMED HEALTH WOMEN'S & CHILDREN'S	35.1	32.8	33.7
UPSTATE CAROLINA MEDICAL CENTER	38.3	37.3	33.9
GREENVILLE MEMORIAL MEDICAL CTR	74.3	69.8	66.8
GREER MEMORIAL/ALLEN BENNETT	68.5	60.4	48.1
HILLCREST MEMORIAL HOSPITAL	61.4	55.0	50.6
PATEWOOD MEMORIAL	---	6.7	10.7
SAINT FRANCIS - DOWNTOWN	76.3	71.9	77.7
SAINT FRANCIS - EASTSIDE	54.9	50.2	56.5
OCONEE MEMORIAL HOSPITAL	54.9	52.3	44.8
CANNON MEMORIAL HOSPITAL	25.6	21.7	18.7
PALMETTO BAPTIST MED CTR EASLEY	45.5	47.6	51.4
MARY BLACK MEMORIAL HOSPITAL	49.0	46.5	44.3
SPARTANBURG REGIONAL MEDICAL CTR	66.1	68.3	72.4
VILLAGE HEALTHCARE CENTRE	---	---	---
WALLACE THOMSON HOSPITAL	26.4	20.8	21.1

	2006	2007	2008
REGION II	**60.8**	**60.3**	**58.4**
ABBEVILLE AREA MEDICAL CENTER	38.4	35.1	36.3
CHESTER REGIONAL MEDICAL CENTER	24.3	24.5	24.4
EDGEFIELD COUNTY HOSPITAL	24.9	23.6	21.6
FAIRFIELD MEMORIAL HOSPITAL	33.9	27.6	34.5
SELF REGIONAL HEALTHCARE	47.8	45.6	43.2
KERSHAW HEALTH	58.7	57.7	61.8
SPRINGS MEMORIAL HOSPITAL	54.6	50.6	50.3
LAURENS COUNTY HOSPITAL	45.9	44.7	44.7
LEXINGTON MEDICAL CENTER	77.3	75.8	73.9
NEWBERRY COUNTY MEM HOSPITAL	34.2	32.2	32.7
PALMETTO HEALTH BAPTIST	60.3	58.6	51.8
PALMETTO HEALTH RICHLAND	71.9	74.7	75.4
PROVIDENCE HOSPITAL	67.7	64.6	58.6
PROVIDENCE HOSPITAL NORTHEAST	73.6	74.0	60.9
PIEDMONT MEDICAL CENTER	72.3	64.9	62.6

	2006	2007	2008
REGION III	**65.6**	**61.8**	**59.9**
CHESTERFIELD GENERAL HOSPITAL	42.0	46.9	52.3
CLARENDON MEMORIAL HOSPITAL	68.7	71.1	68.4
CAROLINA PINES REGIONAL MED CTR	83.0	80.9	72.7
MCLEOD MED CTR - DARLINGTON	24.0	23.6	49.4
MCLEOD MED CTR - DILLON	39.7	41.4	39.2
CAROLINAS HOSPITAL SYSTEM	75.4	61.6	61.5
LAKE CITY COMMUNITY HOSPITAL	24.1	29.9	22.8
MCLEOD REGIONAL MEDICAL CENTER	90.0	73.8	71.4
WOMEN'S CENTER CAROLINAS HOSP	42.2	38.4	49.6
GEORGETOWN MEMORIAL HOSPITAL	68.7	61.7	55.4
WACCAMAW COMMUNITY HOSPITAL	73.1	83.7	81.5
CONWAY HOSPITAL	64.4	65.0	63.9
GRAND STRAND REGIONAL MED CTR	71.6	71.6	72.7
LORIS COMMUNITY HOSPITAL	43.4	44.2	39.3
MARION COUNTY MEDICAL CENTER	51.9	48.6	42.1
MARLBORO PARK HOSPITAL	13.2	17.2	15.4
TUOMEY	74.2	72.4	66.7
WILLIAMSBURG REGIONAL HOSPITAL	32.7	25.4	15.5

	2006	2007	2008
REGION IV	**61.1**	**59.4**	**57.1**
AIKEN REGIONAL MEDICAL CENTER	63.5	63.1	61.9
ALLENDALE COUNTY HOSPITAL	16.4	12.9	14.5
BAMBERG COUNTY MEMORIAL HOSP	27.0	26.4	9.7
BARNWELL COUNTY HOSPITAL	17.4	18.1	18.9
BEAUFORT MEMORIAL HOSPITAL	76.2	65.0	63.9
HILTON HEAD REGIONAL MEDICAL CTR	51.6	55.1	54.9
SUMMERVILLE MEDICAL CENTER	70.3	66.9	60.8
BON SECOURS ST FRANCIS XAVIER	79.1	71.3	50.4
CHARLESTON MEMORIAL HOSPITAL	12.2	18.5	26.8
EAST COOPER MEDICAL CENTER	53.2	49.1	49.3
MUSC MEDICAL CENTER	76.2	80.0	75.7
ROPER HOSPITAL	58.0	57.2	56.4
TRIDENT MEDICAL CENTER	78.3	76.2	68.5
COLLETON MEDICAL CENTER	57.2	49.0	46.5
HAMPTON REGIONAL MEDICAL CENTER	15.4	12.6	12.3
COASTAL CAROLINA MEDICAL CENTER	43.1	45.7	33.6
REG MED CTR ORANGEBURG/CALHOUN	61.1	52.6	59.6

B. Obstetrical and Neonatal Services:

1. Obstetrical Services:

Advances in obstetrical and newborn intensive care offer the promise of lower perinatal mortality and improvement in the quality of life for survivors. The high cost of intensive care and the limited availability of skilled personnel have created the requirement for a more efficient method of resource allocation.

Maternal, fetal, and neonatal mortality and morbidity rates can be significantly reduced if patients at high risk are identified early in the pregnancy and optimum techniques for the care of both the mother and infant are applied. High-risk deliveries are a small percent of total annual deliveries, but these patients require a high degree of specialized care. In 2007, 77.7% of all Very Low Birthweight (VLB) babies were born in either a Level III center or a Regional Perinatal Center.

Infant mortality is defined as the death of babies from birth until their first birthday. South Carolina's infant mortality rate for 2007 was 8.5 infant deaths per 1,000 live births, while the national Healthy People 2010 objective for of no more than 4.5 infant deaths per 1,000 births.

Neonatal mortality is the death rate for infants up to 28 days old. For 2007, South Carolina's neonatal mortality rate for all races was 5.7 neonatal deaths per 1,000 live births versus the Healthy People 2010 national objective of 2.9 neonatal deaths per 1,000 live births.

Because the cost of high-risk obstetrical and neonatal services is so great, it is not desirable or cost-effective for all hospitals in the state to provide the higher levels of care. Over the years, a regionalized approach to perinatal care has been implemented in South Carolina to address the need for high quality, risk-appropriate, cost-effective perinatal health care. Regionalization provides a coordinated system of perinatal care for a well-defined population group. Each hospital providing perinatal services is designated by DHEC's Division of Health Licensing as a Level I, II, IIE (Enhanced), III Perinatal Hospital, or a RPC (Regional Perinatal Center). Each Level I, II, IIE and III hospital maintains a relationship with its designated RPC for consultation, transport and continuing education. Patients are transferred to the appropriate RPC when medically appropriate, if beds are available. In this way, quality care is provided to mothers and newborn infants, and specially trained perinatal personnel and intensive care facilities can be used efficiently and cost-effectively.

The complete descriptions of the five levels of perinatal services are outlined in Section 607.2 of Regulation Number 61-16: http://www.scdhec.net/administration/regs/docs/61-16.pdf

Community Perinatal Center (Level I): These hospitals provide services for uncomplicated deliveries and normal neonates. The hospital has the capability to manage normal pregnant women and uncomplicated labor and delivery of neonates who are at least 36 weeks of gestation with an anticipated birth weight of greater than 2,000 grams. Hospitals must be able to manage a perinatal patient with acute or potentially life-threatening problems while preparing for immediate transfer to a higher level hospital. CON review is not required for a Level I program.

Specialty Perinatal Center (Level II): In addition to Level I requirements, these hospitals provide services for both normal and selected high-risk obstetrical and neonatal patients. This level of neonatal care includes the management of neonates who are at least 32 weeks of gestation with an anticipated birth weight of at least 1,500 grams. A board-eligible pediatrician must be in the hospital or on site within 30 minutes, 24 hours a day and the hospital must have at least a written consultative agreement with a board eligible neonatologist. These hospitals manage a three year average of at least 500 deliveries annually, including the number of maternal transfers made prior to delivery to higher level perinatal hospitals. CON review is not required for a Level II program.

Enhanced Perinatal Center (Level IIE): In addition to Level II requirements, these hospitals provide services for both normal and selected high-risk obstetrical and neonatal patients. Level IIE hospitals may not be located closer than 60 miles from a Regional Perinatal Center. This level of care includes the management of neonates who are at least 30 weeks gestation with an anticipated birth weight of at least 1,250 grams. A board-eligible neonatologist must be in the hospital or on site within 30 minutes, 24 hours a day. These hospitals manage a three year average of at least 1,200 deliveries annually, including the number of maternal transfers made prior to delivery to higher level perinatal hospitals. A Certificate of Need is required for a hospital to provide Enhanced Perinatal Center (Level IIE) services.

Subspecialty Perinatal Center (Level III): In addition to Level IIE requirements, these hospitals provide all aspects of perinatal care, including intensive care and a range of continuously available, sub-specialty consultation as recommended in the fourth edition of the *Guidelines for Perinatal Care* (GPC) by the American Academy of Pediatrics (AAP) and The American College of Obstetricians and Gynecologists. A board eligible neonatologist shall be in the hospital or on site within 30 minutes, 24 hours a day. A board certified perinatologist shall be available for supervision and consultation, 24 hours a day. Level III hospitals have the staffing and technical capability to manage high-risk obstetric and complex neonatal patients, including neonates requiring prolonged ventilatory support, surgical intervention, or 24-hour availability of multispeciality management. These hospitals manage a three year average of at least 1,500 deliveries annually, including the number of maternal transfers made prior to delivery to higher level perinatal hospitals, or at least an average of 125 neonate admissions that weigh less than 1,500 grams each, require ventilatory support, or require surgery. The establishment of a Level III service requires Certificate of Need review.

Regional Perinatal Center (RPC): In addition to the Level III requirements for management of high-risk obstetric and complex neonatal conditions, the RPC shall provide consultative, outreach, and support services to other hospitals in the region. RPCs manage a three year average of at least 2,000 deliveries annually, or at least an average of 250 neonate admissions that weigh less than 1,500 grams each, require ventilatory support, or require surgery. A board-certified maternal-fetal medicine specialist (perinatologist) must be in the hospital or on site within 30 minutes, 24 hours a day. RPCs participate in residency programs for obstetrics, pediatrics, and/or family practice. No more than one Regional Perinatal Center will be approved in each perinatal region. The establishment of a Regional Perinatal Center requires Certificate of Need review.

2008 OB UTILIZATION AND BIRTHS

FACILITY	BIRTHS	OB BEDS	OB ADM	OB PDS	OCC.%
GREENVILLE MEMORIAL MEDICAL CENTER	5,464	59	8,292	17,337	80.5%
PALMETTO HEALTH BAPTIST	3,695	82	5,659	10,570	35.3%
LEXINGTON MEDICAL CENTER	3,378	29	3,474	7,136	67.4%
SPARTANBURG REGIONAL MEDICAL CTR.	2,831	43	3,384	9,393	59.8%
SAINT FRANCIS - EASTSIDE	2,754	35	3,143	8,344	65.3%
MUSC MEDICAL CENTER	2,680				
PALMETTO HEALTH RICHLAND	2,515	48	5,770	12,425	70.9%
TRIDENT MEDICAL CENTER	2,408	25	2,687	6,037	66.2%
PIEDMONT MEDICAL CENTER	2,378	19	2,392	6,045	87.2%
ANMED HEALTH WOMEN'S & CHILDREN'S	2,179	28	1,777	5,014	49.1%
MCLEOD REGIONAL MEDICAL CTR.	2,088	35	2,828	6,569	51.4%
BON SECOURS ST. FRANCIS XAVIER	1,876	15	1,780	1,578	28.8%
BEAUFORT MEMORIAL HOSPITAL	1,826	23	1,826	4,911	58.5%
EAST COOPER MEDICAL CENTER	1,713	27	2,259	5,388	54.7%
SELF REGIONAL HEALTHCARE	1,570	37	2,416	6,204	45.9%
CONWAY HOSPITAL	1,455	16	1,568	3,638	62.3%
REG MED CTR ORANGEBURG-CALHOUN	1,428	27	1,628	4,012	40.7%
AIKEN REGIONAL MEDICAL CENTER	1,310	18	1,738	4,615	70.2%
TUOMEY	1,214	24	756	4,443	50.7%
MARY BLACK MEMORIAL HOSPITAL	1,210	21	1,340	3,275	42.7%
SUMMERVILLE MEDICAL CENTER	1,070	12	958	1,948	44.5%
GRAND STRAND REGIONAL MED CTR	1,019	19	1,333	2,823	40.7%
WOMEN'S CENTER / CAROLINAS HOSP. SYS	1,012	20	1,239	3,629	49.7%
CLARENDON MEMORIAL	882	10	1,072	2,329	63.8%
HILTON HEAD HOSPITAL	749	8	844	1,893	68.3%
SPRINGS MEMORIAL HOSPITAL	744	14	955	2,198	43.0%
ROPER HOSPITAL	666	16	974	2,214	37.9%
CAROLINA PINES REGIONAL MED CTR	648	13	622	2,654	55.9%
PALMETTO BAPTIST MED CTR EASLEY	588	14	862	1,994	39.0%
PROVIDENCE HOSPITAL NORTHEAST	583	6	580	1,137	51.9%
WACCAMAW COMMUNITY HOSPITAL	551	19	1,917	5,229	75.4%
OCONEE MEDICAL CENTER	513	16	491	1,869	32.0%
ALLEN BENNETT/GREER MEMORIAL	493	10	449	1,193	32.6%
GEORGETOWN MEMORIAL HOSPITAL	486	14	777	2,074	40.6%
COLLETON MEDICAL CENTER	460	6	441	1,036	47.3%
KERSHAW HEALTH	447	10	641	1,320	36.2%
LORIS COMMUNITY HOSPITAL	442	8	582	1,300	44.5%
NEWBERRY COUNTY MEMORIAL HOSPITAL	442	3	509	1,034	94.4%
LAURENS COUNTY HOSPITAL	435				
UPSTATE CAROLINA MEDICAL CENTER	425	15	582	1,302	23.8%
MARION COUNTY MEDICAL CENTER	406				
MCLEOD MEDICAL CENTER - DILLON	384	14	410	1,559	30.5%
CHESTERFIELD GENERAL HOSPITAL	188	9	262	733	22.3%
MARLBORO PARK HOSPITAL	170	8	322	641	22.0%
ABBEVILLE COUNTY MEMORIAL HOSPITAL	106	3	119	281	25.7%
WALLACE THOMSON HOSPITAL	93	4	119	277	19.0%
BAMBERG COUNTY MEMORIAL HOSPITAL	79				
HAMPTON REGIONAL MEDICAL CTR	3				
TOTAL BIRTHS	60,056				

The need for obstetrical beds will be evaluated based on information supplied by the Joint Annual Report of Hospitals and other sources. Those facilities experiencing low utilization and in close proximity to one another should consider consolidating services, where appropriate.

Quality

Cesarean sections are identified as a potentially over-used procedure, although an optimal rate has not been determined. While the appropriateness of a c-section depends on the patient's characteristics, it is largely impacted by the individual physician's practice patterns. Hospital rankings need to be risk-adjusted, but, overall, a lower c-section rate is viewed as representing higher quality. Conversely, a higher rate of Vaginal Birth After Cesarean (VBAC) equates to higher quality. To the extent practical, hospitals should attempt to lower their c-section rates. Source: http://www.qualityindicators.ahrq.gov/downloads/iqi/iqi_guide_v31.pdf

Relative Importance of Project Review Criteria

The following project review criteria are considered the most important in evaluating Certificate of Need applications for an obstetrical service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Distribution (Accessibility);
c. Acceptability;
d. Financial Feasibility; and
e. Adverse Effects on Other Facilities.

The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

The following hospitals have requested a Perinatal Capability Review and have been designated as a Level II, Level IIE, Level III or RPC facility:

Regional Perinatal Centers

Greenville Memorial Medical Center
McLeod Regional Medical Center of the Pee Dee
MUSC Medical Center
Palmetto Health Richland
Spartanburg Regional Medical Center

Subspecialty Perinatal Center (Level III Hospital)

Palmetto Health Baptist
Self Regional Healthcare

Enhanced Perinatal Center (Level II Enhanced Care Hospitals)

Piedmont Medical Center

Specialty Perinatal Centers (Level II Hospitals)

Aiken Regional Medical Center
AnMed Health Women's and Children's Hospital
Baptist Easley Hospital
Beaufort Memorial Hospital
Bon Secours-St. Francis Xavier Hospital
Carolina Pines Regional Medical Center
Conway Hospital
East Cooper Medical Center
Georgetown Memorial Hospital
Grand Strand Regional Medical Center
Lexington Medical Center
Marion County Medical Center
Mary Black Memorial Hospital
Regional Medical Center of Orangeburg/Calhoun Counties
Roper Hospital
St. Francis - Eastside
Springs Memorial Hospital
Summerville Medical Center
Trident Medical Center
Tuomey
Waccamaw Community Hospital
The Women's Center of Carolinas Hospital System

2. Neonatal Services:

Neonatal services are highly specialized and are only required by a very small percentage of infants. The need for these services is affected by the incidence of high-risk deliveries, the percentage of live births requiring neonatal services, and the average length of stay. The limited need for these services requires that they be planned for on a regional basis, fostering the location of these specialized units in hospitals that have the necessary staff, equipment, and consultative services and facilities. Referral networks facilitate the transfer of infants requiring this level of services from other facilities.

The inventory of Intensive and Intermediate Bassinets by Perinatal Region is as follows:

Perinatal Region	Existing Bassinets Intensive	Intermediate
Anderson, Abbeville, Edgefield, Greenville, Greenwood, Laurens, McCormick, Oconee, Pickens, Saluda		
Palmetto Baptist Medical Center - Easley	0	4
Greenville Memorial Medical Center	12	68
AnMed Health Women's & Children's Hospital	0	13
St. Francis Women's & Family Hospital	0	10
Self Regional Healthcare	7	11
SUBTOTAL	19	106
Cherokee, Chester, Spartanburg, Union		
Spartanburg Regional Medical Center	13	22
Mary Black Memorial Hospital	0	10
SUBTOTAL	13	32
Aiken, Allendale, Bamberg, Barnwell, Calhoun, Clarendon, Fairfield, Kershaw, Lancaster, Lee, Lexington, Newberry, Orangeburg, Richland, Sumter, York		
Palmetto Health Richland	31	34
Palmetto Health Baptist	8	22
Lexington Medical Center	0	20
Piedmont Medical Center	0	12
Springs Memorial Hospital	0	4
Aiken Regional Medical Center	0	8
Regional Med Center Orangeburg-Calhoun	0	10
Tuomey	0	22
SUBTOTAL	39	132
Chesterfield, Darlington, Dillon, Florence, Horry, Marion, Marlboro, Williamsburg		
Carolina Pines Regional Medical Center	0	4
Marion County Medical Center	0	2
McLeod Regional Medical Ctr. of Pee Dee	12	28
Conway Hospital	0	6
Grand Strand Regional Medical Center	0	2
Women's Center of Carolinas Hospital System	0	11
SUBTOTAL	12	53
Beaufort, Berkeley, Charleston, Colleton, Dorchester, Hampton, Jasper, Georgetown		
Beaufort Memorial Hospital	0	5
Georgetown Memorial Hospital	0	5
Waccamaw Community Hospital	0	2
MUSC Medical Center	16	50
East Cooper Medical Center	0	10
Bon Secours-St. Francis Xavier Hospital	0	11
Summerville Medical Center	0	3
Trident Medical Center	0	10
Roper Hospital	0	5
SUBTOTAL	16	101
STATEWIDE TOTAL	99	424

The 2008 utilization of neonatal special care units by facility follows. Note not all facilities reported utilization of their intermediate bassinets.

2008 Utilization Hospital	ICU Bassinets	ICU Pt Days	Intermed Bassinets	Intermed Pt Days	Total Bassinets	Total Pt Days	Total Occupancy
AnMed Health Women's			13	1,033	13	1,033	21.8%
Greenville Memorial	12	5,625	68	11,398	80	17,023	58.3%
St. Francis-Eastside			10	1,921	10	1,921	52.6%
Palmetto Baptist-Easley			4	0	4	0	0.0%
Self Regional	7	660	11	2,738	18	3,398	51.7%
REGION SUBTOTAL	19	6,285	106	17,090	125	23,375	51.2%
Mary Black Memorial			10	667	10	667	18.3%
Spartanburg Regional	13	4,503	22	3,665	35	8,168	63.9%
REGION SUBTOTAL	13	4,503	32	4,332	45	8,835	53.8%
Aiken Regional Med Ctr			8	369	8	369	12.6%
Springs Memorial Hosp			4	933	4	933	63.9%
Lexington Medical Ctr			20	3,372	20	3,372	46.2%
Reg Med Ctr Orangeburg			10	0	10	0	0.0%
Palmetto Health Baptist	8	1,796	22	4,937	30	6,733	61.5%
Palmetto Health Richland	31	8,481	34	11,783	65	20,264	85.4%
Tuomey			22	463	22	463	5.8%
Piedmont Medical Ctr			12	1,684	12	1,684	38.4%
REGION SUBTOTAL	39	10,277	132	23,541	171	33,818	54.2%
Carolina Pines Regional			4	97	4	97	6.6%
McLeod Regional	12	4,089	28	4,696	40	8,785	60.2%
Women's Ctr Carolinas			11	1,055	11	1,055	26.3%
Conway Hospital			6	537	6	537	24.5%
Grand Strand Regional			2	272	2	272	37.3%
Marion Co Medical Ctr			2	0	2	0	0.0%
REGION SUBTOTAL	12	4,089	53	6,657	65	10,746	45.3%
Beaufort Memorial Hosp			5	0	5	0	0.0%
Bon Secours-St. Francis			11	1,183	11	1,183	29.5%
East Cooper Medical Ctr			10	251	10	251	6.9%
MUSC Medical Center	16	7,192	50	11,448	66	18,640	77.4%
Roper Hospital			5	172	5	172	9.4%
Trident Medical Center			10	1,672	10	1,672	45.8%
Summerville Med. Ctr.			3	855	3	855	78.1%
Georgetown Memorial			5	67	5	67	3.7%
Waccamaw Community			2	87	2	87	11.9%
REGION SUBTOTAL	16	7,192	101	15,735	117	22,927	53.7%
GRAND TOTAL	99	32,346	424	67,355	523	99,701	52.2%

The projected need for neonatal intensive care bassinets is calculated based on the utilization of the individual Level III and Regional Perinatal Centers using a 65% occupancy factor. This allows for a potential increase in bassinets given the small number of bassinets needed. In most areas, the utilization of intensive care bassinets is high and there is a need for additional intensive care bassinets. Only Level III and RPCs neonatal units have intensive care bassinets.

The projected need for intermediate neonatal bassinets was calculated using the preceding methodology. Note that some Level II hospitals did not report any utilization for the intermediate care bassinets and the occupancy rate is reflected as zero, which decreases the need calculations. The addition of neonatal intermediate care bassinets does not require Certificate of Need review.

Note: S.C. presently has 1.57 neonatal intensive care bassinets and 7.10 neonatal intermediate care bassinets per 1,000 births.

In some areas the number of intensive care bassinets should be increased. The intermediate care bassinets should be better utilized in Level II and Level IIE facilities so babies can be transferred back closer to their home community potentially alleviating the high utilization of the current intensive/intermediate care bassinets in RPC facilities in some areas of the State. To improve the availability of the existing RPC neonatal intensive care bassinets, utilization of the back transport concept should be supported. This component of regionalized care involves the transfer of infants who no longer require neonatal intensive care to facilities with intermediate or continuing care bassinets appropriate to the individual baby's care needs. If more back transfers to the Level II and/or Level IIE facilities occurred, then some of the overcrowding problems of the existing RPC units would be alleviated.

It should be noted that some RPC and Level III facilities with intensive care bassinets may at times have intermediate type infants in intensive care bassinets and vice versa as the patient load changes within the unit. RPCs may use intermediate and intensive care bassinets interchangeably as the level of care required by the neonate varies.

Relative Importance of Project Review Criteria

The following criteria are considered the most important in evaluating certificate of need applications for a neonatal service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Distribution (Accessibility);
c. Acceptability
d. Financial Feasibility; and
e. Adverse Effects on Other Facilities.

Because neonatal services are planned and located regionally due to the very small percentage of infants requiring neonatal services, this service is available within approximately 90 minutes for the

majority of the population. Of more importance is the early identification of mothers who potentially will give birth to a baby needing this specialized service and directing them to the appropriate neonatal center. There is a need for additional intensive care bassinets in some areas. A few additional Level II (intermediate) bassinets are needed; however, the existing intermediate care bassinets are not used in some hospitals. The benefits of improved accessibility will be equally weighed with the adverse affects of duplication in evaluating Certificate of Need applications for this service.

NICU BASSINET CALCULATIONS

Hospital (RPC)	Existing Bassinets	2008 Pt Days	NICU ADC	Occupancy Factor	Projected Need	To Be Added
Greenville Memorial	12	5,625	15	0.65	24	12
Spartanburg Regional	13	4,503	12	0.65	19	6
Self Regional	7	660	2	0.65	3	-4
Palmetto Health Richland	31	8,481	23	0.65	36	5
Palmetto Health Baptist	8	1,796	5	0.65	8	0
McLeod Regional	12	4,089	11	0.65	17	5
MUSC Medical Center	16	7,192	20	0.65	30	14
Totals	99	32,346	88		136	37

INTERMEDIATE BASSINET NEED

Hospital	Intermed Bassinets	2008 Pt Days	Intermed ADC	Occupancy Factor	Projected Need	To Be Added
AnMed Health Women's	13	1,033	3	0.65	4	-9
Greenville Memorial	68	11,398	31	0.65	48	-20
St. Francis-Eastside	10	1,921	5	0.65	8	-2
Palmetto Baptist-Easley	4	0	0	0.65	0	-4
Spartanburg Regional	22	3,665	10	0.65	15	-7
Mary Black Memorial	10	667	2	0.65	3	-7
Self Regional	11	2,738	7	0.65	12	1
Aiken Regional Med Ctr	8	369	1	0.65	2	-6
Springs Memorial Hosp	4	933	3	0.65	4	0
Lexington Medical Ctr	20	3,372	9	0.65	14	-6
Reg Med Ctr Orangeburg	10	0	0	0.65	0	-10
Palmetto Health Baptist	22	4,937	13	0.65	21	-1
Palmetto Health Richland	34	11,783	32	0.65	50	16
Tuomey	22	463	1	0.65	2	-20
Piedmont Medical Ctr	12	1,684	5	0.65	7	-5
Carolina Pines Regional	4	97	0	0.65	0	-4
McLeod Regional Med Ctr	28	4,696	13	0.65	20	-8
Women's Ctr Carolinas	11	1,055	3	0.65	4	-7
Conway Hospital	6	537	1	0.65	2	-4
Grand Strand Regional	2	272	1	0.65	1	-1
Marion Co Medical Ctr	2	0	0	0.65	0	-2
Beaufort Memorial Hosp	5	0	0	0.65	0	-5
Bon Secours-St. Francis	11	1,183	3	0.65	5	-6
East Cooper Med Ctr	10	251	1	0.65	1	-9
MUSC Medical Center	50	11,448	31	0.65	48	-2
Roper Hospital	5	172	0	0.65	1	-4
Trident Medical Center	10	1,672	5	0.65	7	-3
Summerville Med. Ctr.	3	855	2	0.65	4	1
Georgetown Memorial	5	67	0	0.65	0	-5
Waccamaw Community	2	87	0	0.65	0	-2
Totals	424	67,355	184		283	-141

C. Pediatric Inpatient Services:

A pediatric inpatient unit is a specific section, ward, wing or unit devoted primarily to the care of medical and surgical patients less than 18 years old, not including special care for infants. It is recognized that children have special problems that need to be addressed by specialized facilities, equipment and personnel experienced in dealing with children, and understanding and sympathetic to the child's unique needs. It is also recognized that each hospital need not develop the capability to provide all types of pediatric care. Pediatric beds are licensed as general hospital beds and no separate need is calculated for them.

Quality

The Agency for Health Research and Quality (AHRQ) lists 13 provider-level quality indicators for pediatric services. Not all indicators are applicable for all hospitals. These include: accidental puncture and laceration; decubitus ulcer; foreign body left in during a procedure; iatrogenic pneumothorax in neonates and non-neonates; in-hospital mortality for pediatric heart surgery; volume of pediatric heart surgery; post-operative hemorrhage or hematoma; post-operative respiratory failure; post-operative sepsis; post-operative wound dehiscence (opening of a wound along the suture line); infection due to medical care; and transfusion reaction. South Carolina hospitals should be lower than or comparable to the national averages for these indicators. Link: http://www.qualityindicators.ahrq.gov/downloads/pdi/2006-Feb-PediatricQualityIndicators.pdf

Relative Importance of Project Review Criteria

The following criteria are considered the most important in evaluating certificate of need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Distribution (Accessibility);
c. Acceptability;
d. Financial Feasibility; and
e. Adverse Effects on Other Facilities.

In many hospitals, pediatric beds/services are not physically separated from other general hospital beds. Only larger hospitals have distinct pediatric units. General hospital beds are located within approximately 30 minutes travel time for the majority of the residents of the State. There may be a need for additional pediatric beds in the existing general hospitals; however, additional beds for pediatric services will not be approved unless other beds are converted to pediatrics or a need is indicated in the Plan for additional hospital beds. The benefits of improved accessibility do not outweigh the adverse affects caused by the duplication of this existing service.

D. Long-Term Acute Care Hospitals:

Long Term Acute Care Hospitals (LTACHs) provide treatment to patients with complex medical conditions, such as strokes, cardiac care, ventilator dependency, wound care and post-surgical care. These patients require up to 3 hours per day of rehabilitative treatment and have an average length of stay of 25 days or longer. Medicare pays for about 73% of all LTACH discharges; the standard federal reimbursement for 2009 was $39,114.36 per patient.

There are more than 350 LTACHs nationwide, and they may be either a freestanding facility, or may occupy space in another hospital ("hospital-within-a-hospital"). Hospitals must meet additional Federal criteria in order to qualify as a LTACH Hospital under the "hospital-within-a-hospital" model:

1. The new hospital must have a governing body, which is distinct and separate from the governing body of the host hospital, and the new body cannot be under the control of the host hospital or any third entity that controls both hospitals.

2. The LTACH must have a separate Chief Executive Officer through whom all administrative authority flows, who is not employed by, or under contract with, the host hospital or any third entity that controls both hospitals.

3. The hospital must have a separate Chief Medical Officer who reports directly to the governing body and is responsible for all medical staff activities. The Chief Medical Officer cannot be under contract with the host hospital or any third entity that controls both hospitals.

4. The hospital must have a separate medical staff from the medical staff of the host hospital, which report directly to the governing body, and adopt bylaws governing medical care, including granting privileges to individual practitioners.

LTACHs have their own Prospective Payment System (PPS). In 2006, CMS established a "25% payment threshold policy" for hospitals-within-hospitals. If the LTACH's Medicare discharges exceed 25% from the host hospital, the LTACH would be paid the lesser of the otherwise payable amount under the LTACH PPS or the equivalent amount that Medicare would have paid under the Acute Care Hospital Inpatient PPS.

CMS had proposed revising the reimbursement policy and extending the 25% rule to all LTACHs; if any LTACH gets more than 25% of its admissions from a single hospital it will receive less reimbursement. However, legislation was signed that would provide regulatory relief for 3 years and impose a limited moratorium on the development of new facilities. The LTACH DRGs were re-weighted in 2009 and CMS proposed a 2.2% payment increase for FY 2010.

The existing LTACHs in South Carolina and their occupancy rates are:

FACILITY	COUNTY	BEDS	2006	2007	2008
NORTH GREENVILLE LONG TERM ACUTE	GREENVILLE	45	53.9	48.6	58.0
REGENCY HOSPITAL OF GREENVILLE	GREENVILLE	32	88.4	78.6	74.2
SPARTANBURG HOSP RESTORATIVE CARE	SPARTANBURG	97	36.0	36.1	33.2
INTERMEDICAL HOSPITAL OF SC	RICHLAND	35	66.5	75.5	66.0
REGENCY HOSPITAL OF SC *1*	FLORENCE	40	90.8	86.4	73.7
SAVANNAH RIVER SPECIALTY HOSPITAL *2*	AIKEN	(34)	---	---	---
KINDRED HOSPITAL CHARLESTON	CHARLESTON	59	49.4	50.8	50.4
	TOTAL	308			

1 CON issued 8/30/06 to add 12 beds for a total of 40; licensed 8/8/07.
2 CON issued 3/27/07; voided 4/15/08.

Certificate of Need Standards

1. An application for a Long Term Acute Care Hospital must be in compliance with the relevant standards in Regulation No. 61-16, Licensing Standards for Hospital and Institutional General Infirmaries.

2. Although Long Term Acute Care Hospital beds are not considered to be a separate category for licensing purposes, they will be inventoried separately from general acute care hospital beds for planning purposes.

3. The utilization of LTACHs is not included in the bed need for general acute care hospital beds. No bed need will be calculated for Long Term Acute Care Hospital beds. An applicant must document the need for LTACH beds based on the utilization of existing LTACH beds.

4. A hospital that has leased general beds to a Long Term Acute Care Hospital shall be entitled to regain these beds once the lease is terminated. No entity other than the hospital that initially leased the general acute beds (or its successor) to the Long Term Acute Care Hospital shall be entitled to obtain the rights to the beds upon termination of the lease. A Certificate of Need application is required:

   A. a hospital may be allowed to convert these former LTACH beds to general acute hospital beds regardless of the projected need for general acute beds;

B. a hospital may be allowed to convert these former LTACH beds to psychiatric, inpatient treatment facility, rehabilitation, or other specialty beds only if there is a bed need projected for this proposed other category of licensed beds.

5. A hospital which desires to be designated as an LTACH and has been awarded a CON for that purpose, must be certified as an LTACH by CMS within 24 months of accepting its first patient, or the CON issued to that hospital for that purpose shall be revoked. The entity that has had its CON revoked shall not have the authority to operate as a general acute care hospital.

Quality

The DHEC Hospital Acquired Infections (HAI) report includes a standardized Central Line Associated Blood Stream Infections (CLABSI) ratio for LTACHs. All South Carolina LTACHs should be lower than or not different from their statistically expected ratios. For temporary central lines in 2009, Intermedical Hospital had statistically significantly fewer CLABSIs than projected. The Regency Hospitals in Florence and Greenville were within their expected ranges, while kindred Hospital, North Greenville LTACH and Spartanburg Hospital for Restorative Care had higher than expected rates. Source:
http://www.scdhec.gov/health/disease/hai/docs/Table%207.%20Long%20Term%20Acute%20Care%20Unit.pdf

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating certificate of need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Financial Feasibility.

Long Term Acute Care Hospital beds are located within approximately sixty (60) minutes travel time for the majority of the residents of the State. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for these beds.

E. Critical Access Hospitals:

Rural counties tend to have higher unemployment and a preponderance of low-paying jobs that do not provide health insurance; a greater percentage of their population are elderly. Rural hospitals are usually smaller than urban hospitals, with fewer physicians and other health care professionals, and diagnostic and therapeutic technology is generally less available. They typically have a high Medicare and Medicaid case mix, but receive lower reimbursement from Medicare than urban facilities. At the same time, many rural hospitals are the sole community provider and one of the major employers in the community. The loss of a rural hospital has a major impact on the delivery of health services for the citizens of a community.

The Medicare Rural Hospital Flexibility Program allows the designation of Critical Access Hospitals (CAHs). These hospitals are eligible for cost-based reimbursement without having to meet all criteria for full-service acute care hospitals. They are intended to provide essential health services to rural communities; converting a struggling rural hospital to a CAH can allow a community to maintain local health access that would otherwise be lost.

The following criteria must be met in order for a facility to qualify as a CAH:

1. It must be located in a rural county. It may be either an existing facility or a hospital that closed or downsized to a health center or clinic after November 29, 1989. A facility may be allowed to relocate or rebuild provided it meets the CMS criteria.

2. The facility must be part of a rural health network with at least one full-service hospital, with agreements regarding patient referral and transfer, communications, and patient transportation;

3. The facility must be located more than 35 miles from any other hospital or CAH (15 miles for areas with only secondary roads) or must have been certified by the State prior to January 1, 2006 as being a necessary provider of health care services to residents of the area;

4. The maximum number of licensed beds is 25, which can be operated as any combination of acute or swing-beds;

5. Required services include: inpatient care, emergency care, laboratory and pharmacy;

6. Emergency services must be available 24 hours a day, with on-call personnel available within 30 minutes. CMS requires that any hospital, including a CAH, that does not have a physician on site 24 hours per day, 7 days per week, provide a notice to all patients upon admission that addresses how emergency services are provided when a physician is not on site.

7. The medical staff must consist of at least one physician. Staffing must include nursing on a 24-hour basis; other staffing can be flexible. Nurse Practitioners, Physician Assistants and Clinical Nurse Specialists can provide inpatient care without their supervising physician(s) being on-site.

8. The annual average length of stay must be less than 96 hours (4 days).

In South Carolina, a hospital located in an urban Metropolitan Statistical Area (MSA) county can still be considered "rural" for the purposes of the CAH program if it meets the following criteria:

1. It is enrolled as both a Medicaid and Medicare provider and accepts assignment for all Medicaid and Medicare patients;

2. It provides emergency health care services to indigent patients;

3. It maintains a 24-hour emergency room;

4. It staffs 50 or fewer acute care beds; and

5. It is located in a county with 25% or more rural residents, as defined by the most recent Census.

A total of 1,305 hospitals nationwide had been approved for CAH status as of July 2009. The impact of the Critical Access Hospital Program in South Carolina is a financial one, allowing cost-based reimbursement from Medicare for a facility choosing to participate. The designation as a CAH does not require a change in the licensing of an existing hospital. However, a hospital may be required to de-license a number of beds in order to meet the 25-bed requirement.

The following facilities in South Carolina are designated as CAHs:

Abbeville Memorial Hospital
Allendale County Hospital
Edgefield County Hospital
Fairfield Memorial Hospital
Williamsburg Regional Hospital

Based on their 2008 Average Daily Census (ADC), the following hospitals in South Carolina could potentially participate in the CAH program: Cannon Memorial (10.3), McLeod-Darlington (24.8), Lake City Community (11.0), Marlboro Park (14.5), Bamberg County Memorial (5.8), Barnwell Hospital (10.0), Hampton Regional (8.4), and Coastal Carolina Medical Center (10.4).

The designation of a hospital as a Critical Access Hospital does not require Certificate of Need review, because it does not change the licensing category of the facility. However, an exemption from Certificate of Need review is required for a hospital to reduce the number of licensed beds in order to meet the criteria for a CAH. Should a hospital later desire to revert to a general acute hospital, a Certificate of Need is required, but the facility may be permitted to increase the number of licensed hospital beds up to the prior number of beds.

F. Pediatric Long Term Acute Care Hospitals:

Pediatric Long Term Care Hospitals (PLATCHs) are specialized health care facilities designed to provide care for children up to age 21 who have complex medical conditions that require extensive care on a long-term basis (similar to adult LTACHs). Care may be rehabilitative or palliative. These facilities are designed to be as non-institutional as possible while meeting the psychological, physical, and emotional needs of chronically ill children and their families. To be admitted, children must have ongoing health conditions that require both medical and nursing supervision and specialized equipment or services.

Patients often have three or more chronic conditions. These may include Neonatal Abstinence Syndrome (NAS), birth defects, spinal cord or trauma injury, seizure disorders, chronic lung disease, and extensive wound care. Many are non-ambulatory and dependent on medical technology such as ventilators, feeding tubes, IV infusions, and mobility devices.

The DHEC Division of Children with Special Health Care Needs has a caseload of approximately 12,000 children and it is envisioned that many of these clients would be candidates for Pediatric LTACH services. These patients are currently either staying for extended periods in one of the state's Children's Hospitals (Greenville Hospital System, Palmetto Health, McLeod, and MUSC) or are receiving daily therapy in their own homes. Neither option is optimal for these patients.

Pediatric LTACH facilities are currently located primarily in the Northeast and California. They are potentially a less costly alternative to maintaining these children in an acute care facility. Some states have nursing homes that specialize in extended care for pediatric patients, but there are currently no such facilities in South Carolina.

Certificate of Need Standards

1. An application for a Pediatric Long Term Acute Care Hospital must be in compliance with the relevant standards in DHEC Regulation No. 61-16, Licensing Standards for Hospitals and Institutional General Infirmaries.

2. Although Pediatric Long Term Acute Care Hospital beds are not considered to be a separate category for licensing purposes, they will be inventoried separately from general acute care hospital beds for planning purposes.

3. The utilization of PLTACHs is not included in the bed need for general acute care hospital beds. No bed need will be calculated for Pediatric Long Term Acute Care Hospital beds. An applicant must document the need for PLTACH beds.

4. An applicant for PLTACH beds must submit an affiliation agreement with a SC Children's Hospital. This affiliation agreement will at a minimum include a transfer agreement and coverage for specialized medical services.

5. Should a hospital lease general beds to another entity to create a Pediatric Long Term Acute Care Hospital, that hospital shall be entitled to regain these beds once the lease is terminated. No entity other than the hospital that initially leased the general acute beds (or its successor) to the Pediatric Long Term Acute Care Hospital shall be entitled to obtain the rights to the beds upon termination of the lease. A Certificate of Need application is required.

6. A hospital that desires to be designated as a Pediatric LTACH must restrict admissions to patients under the age of 21 who require long-term medical care. Should the facility attempt to provide care that is inconsistent with this requirement, the CON issued to that hospital for that purpose shall be revoked. The entity that has had its CON revoked shall not have the authority to operate as a general acute care hospital.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating certificate of need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Financial Feasibility.

There are currently no Pediatric Long Term Acute Care Hospital beds in South Carolina. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for these beds.

CHAPTER IV

PSYCHIATRIC SERVICES

A. Community Psychiatric Beds:

Inpatient psychiatric services are those services provided to patients who are admitted to institutions for the evaluation, diagnosis, and treatment of mental, emotional, or behavioral disorders. Such services may be provided in either psychiatric units of general hospitals or freestanding psychiatric hospitals.

Special units for children and adolescents and geriatric patients have been developed throughout the state. If any additional beds are approved, they must come from the overall psychiatric bed component shown as needed. These specialty psychiatric services should be identifiable units with sufficient space to have available areas for sleeping, dining, education, recreation, occupational therapy and offices of evaluation and therapy. The unit should be staffed with an appropriate multi-disciplinary care team of psychiatrists, psychologists, social workers, nurses, occupation therapists, recreational therapists, and psychiatric technicians. Other consultants should be available as needed.

The following psychiatric programs are currently available:

Region	Facility	County	Beds	2008 Occupancy	
I	AnMed Health Medical Ctr.	Anderson	38	43.2%	
I	Carolina Ctr. Behavioral Health	Greenville	99	85.0%	*1*
I	Greenville Memorial Med. Ctr.	Greenville	46	84.6%	
I	Springbrook Behavioral Health	Greenville	37	58.6%	*2*
I	Mary Black Memorial	Spartanburg	15	79.9%	
I	Spartanburg Regional Med. Ctr.	Spartanburg	56	35.6%	
II	Self Memorial Regional	Greenwood	36	30.4%	
II	Three Rivers Behavioral Health	Lexington	81	98.8%	*3*
II	Palmetto Health Baptist	Richland	94	64.3%	*3*
II	Palmetto Health Richland	Richland	60	30.2%	
II	Piedmont Medical Center	York	20	39.6%	
III	McLeod – Darlington	Darlington	23	55.2%	
III	Carolinas Hospital System	Florence	12	36.1%	
III	Lighthouse of Conway	Horry	44	65.0%	
III	Marlboro Park Hospital	Marlboro	8	0.0%	
IV	Aiken Regional Med. Ctr.	Aiken	29	98.8%	
IV	Beaufort Memorial	Beaufort	14	47.5%	
IV	Medical University SC	Charleston	82	77.8%	
IV	Palmetto Lowcountry Behavioral	Charleston	70	58.3%	*4*
IV	RMC – Orangeburg & Calhoun	Orangeburg	15	59.9%	
		Total	879	61.4%	

1 CON issued 8/10/09 to add 23 beds for a total of 99; 8 additional beds licensed for a total of 84 2/16/10.

2 CON issued 8/10/09 to add 17 beds for a total of 37.

3 CON issued 7/18/06 to add 32 beds for a total of 71 at Three Rivers. The CON was voided and then re-issued on appeal 12/14/07. CON issued 2/13/08 to transfer 10 psych beds from Palmetto Baptist to Three Rivers in exchange for 10 substance abuse beds to be transferred to Palmetto Baptist. Three Rivers licensed for 49 beds 7/21/08; licensed for 81 beds 7/10/09. Palmetto Baptist licensed for 94 beds 7/21/08.

4 CON issued 10/18/04 to add 10 beds for a total of 70; licensed 3/25/08.

Certificate of Need Standards

1. Need projections are based on psychiatric service areas.

2. The bed need methodology takes the greater of the actual utilization of the facilities in the service area or the statewide average beds per 1,000 population to project need.

3. For service areas without existing psychiatric units and related utilization data, the statewide average beds per 1,000 population was used in the projections.

4. Priority should be given to excess general hospital beds that can be economically and cost effectively converted for use as a specialized psychiatric unit over the construction of new beds, if such beds will be accessible to the target population.

B. State Mental Health Facilities:

1. Psychiatric Hospital Beds:

The S.C. Department of Mental Health (DMH) operates a variety of psychiatric facilities. The Department has analyzed the patient population and plans to provide psychiatric services in the least restrictive environment, maintain patients in the community, and keep hospitalization to a minimum. Since DMH cannot refuse any patient assigned to them by a court, renovation, replacement, and expansion of the component programs should be allowed as long as the overall psychiatric hospital complement is maintained or reduced. As long as the Department of Mental Health does not add any additional beds over the 3,720 beds that were in existence on July 1, 1988, any changes in facility bed capacity are exempt from Certificate of Need review.

2. Local Inpatient Crisis Stabilization Beds:

Because the South Carolina Department of Mental Health (SCDMH) has had substantial decreases over the past several years in inpatient capacity, insufficient adult inpatient beds are available to meet the demand from referral sources for its beds. In a number of regions of the State, this has led to

significant numbers of persons in a behavioral crisis waiting in hospital emergency rooms inordinate periods of time for an appropriate inpatient psychiatric bed to become available. These emergency room patients may not have a source of funding.

SCDMH has attempted to alleviate this problem by means of its "Crisis Stabilization Program." Within available funding limits, the "Crisis Stabilization Program" is to provide short-term emergency stabilization of psychiatric patients in the local community, by use of both local hospital beds and non-hospital residential programs, such as community residential care facilities, for those patients who do not require a hospital level of care. For patients needing stabilization in a hospital, subject to available funding, the SCDMH contracts with one or more local hospitals willing to admit indigent patients assessed by the SCDMH mental health center as needing acute care in return for a daily rate for a defined period. These patients can be cared for in licensed general acute care beds or licensed psychiatric beds.

Due to the low utilization, the Plan only projects a need for a small number of additional psychiatric beds in some service areas. To assist in alleviating the problems described above, the following policies will apply.

1. Should a hospital propose to contract with the SCDMH to provide Crisis Stabilization services in existing acute care or existing psychiatric beds, then a Certificate of Need is not required.

2. Should a hospital propose to contract with the SCDMH to provide Crisis Stabilization services and desire to add psychiatric beds, a Certificate of Need is required. These additional beds could be approved if the Plan indicates a need for additional beds or some small number (ten beds or less) of additional beds could be approved for crisis stabilization patients only. These beds would not be restricted to any specific age group except that the patients would have to be over age 18.

3. An application for a Certificate of Need for Crisis Stabilization patients only must be accompanied by information from the SCDMH to verify this additional need, such as the number of patients currently awaiting treatment, the estimated average length of stay, the pay source for the patients, the number of patients emergently admitted to SCDMH hospitals over the past year from the area, the number of crisis patients that are expected to require this service annually, and other information to justify these additional psychiatric beds. In addition, the SCDMH will supply verification that it made contact with all hospitals in the county and contiguous counties to notify them of the potential for adding some psychiatric beds to the area. The hospital seeking the Certificate of Need will provide the necessary care for these individuals referred by the SCDMH and may be reimbursed by for the care of the patients if there are sufficient funds, but the hospital must identify the minimum number of indigent (no source of funding) patient days it will provide to patients referred by SCDMH. Should the contract with SCDMH terminate for any reason or should the hospital fail to provide care to the patients referred from the SCDMH, the license for these beds will be voided.

Based upon on-going patient analysis by DMH, consideration should be given to converting psychiatric hospital beds to other levels of care in order to accommodate the level of functioning of the patients if alternative community-based resources are not available. DMH will justify any changes in bed or service categories. Patients appropriate for de-institutionalization should be discharged when the appropriate community support services are in place.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating Certificate of Need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Acceptability;
e. Financial Feasibility;
f. Ability of the Applicant to Complete the Project;
g. Cost Containment; and
h. Staff Resources.

Psychiatric beds are planned for and located within sixty (60) minutes travel time for the majority of the residents of the State. In addition, current utilization and population growth are factored into the methodology for determining psychiatric bed need. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for these services.

PSYCHIATRIC BED UTILIZATION

COUNTY	FACILITY	BEDS	2008 OCC. RATE	
AIKEN	AIKEN REGIONAL MEDICAL CENTER	29	98.8%	
ANDERSON	ANMED HEALTH MEDICAL CENTER	38	43.2%	
BEAUFORT	BEAUFORT MEMORIAL	14	47.5%	
CHARLESTON	MEDICAL UNIVERSITY SC	82	77.8%	
CHARLESTON	PALMETTO LOWCOUNTRY BEHAV	70	58.3%	*1*
DARLINGTON	MCLEOD DARLINGTON	23	55.2%	
FLORENCE	CAROLINAS HOSPITAL SYSTEM	12	36.1%	*2*
GREENVILLE	CAROLINA CTR BEHAV. HEALTH	99	85.0%	*3*
GREENVILLE	GREENVILLE MEMORIAL	46	84.6%	
GREENVILLE	SPRINGBROOK BEHAVIORAL HEALTH	37	58.6%	*4*
GREENWOOD	SELF MEM REGIONAL HEALTHCARE	36	30.4%	
HORRY	LIGHTHOUSE - CONWAY	44	65.0%	
LEXINGTON	THREE RIVERS BEHAV HEALTH	81	98.8%	*5*
MARLBORO	MARLBORO PARK HOSPITAL	8	0.0%	
ORANGEBURG	RMC-ORANGEBURG/CALHOUN	15	59.9%	
RICHLAND	PALMETTO BAPTIST - COLUMBIA	94	64.3%	*5*
RICHLAND	PALMETTO RICHLAND MEMORIAL	60	30.2%	
SPARTANBURG	MARY BLACK MEMORIAL	15	79.9%	
SPARTANBURG	SPARTANBURG REGIONAL	56	35.6%	
YORK	PIEDMONT MEDICAL CENTER	20	39.6%	
	TOTAL	879	61.4%	

1 CON ISSUED 10/18/04 TO ADD 10 PSYCH BEDS FOR A TOTAL OF 70; LICENSED 3/25/08.
2 CON APPROVED 2/24/06 TO ADD 24 CRISIS STABILIZATION PSYCH BEDS; APPEALED. BY ALJ ORDER, A 14 BED UNIT WAS APPROVED; 12 OF THE 14 BEDS WERE LICENSED 4/25/07. THE 2 REMAINING APPROVED BEDS WERE RELEASED BY THE HOSPITAL 7/9/08.
3 CON ISSUED 8/10/09 TO ADD 23 BEDS FOR A TOTAL OF 99.
4 CON ISSUED 8/10/09 TO ADD 17 BEDS FOR A TOTAL OF 37.
5 CON ISSUED 7/18/06 TO ADD 32 PSYCH BEDS FOR A TOTAL OF 71 AT THREE RIVERS. CON VOIDED ON 4/17/07. AFTER APPEAL, A NEW CON WAS ISSUED 12/14/07. CON ISSUED 2/13/08 TO TRANSFER 10 PSYCH BEDS FROM PALMETTO BAPTIST TO THREE RIVERS IN EXCHANGE FOR 10 SUBSTANCE ABUSE BEDS. THREE RIVERS LICENSED FOR 49 BEDS 7/21/08; LICENSED FOR 81 BEDS 7/10/09. PALMETTO BAPTIST LICENSED FOR 94 BEDS 7/21/08.

PSYCHIATRIC BED NEED

SERVICE AREA	AGE CAT	2008 POP	2015 POP	EXIST BEDS	2008 PDS	PROJ ADC	% OCC	BED NEED (USE)	+/-	BED NEED (SW)	+/-	BED NEED
ANDERSON,OCONEE	<65	212,270	222,220		4,322	12.40						
	+65	38,430	46,230		1,687	5.56						
	TOTAL	250,700	268,450	38	6,009	17.96	0.70	26	-12	56	18	18
GREENVILLE,PICKENS	<65	473,060	505,860		35,285	103.37						
	+65	62,520	74,210		6,876	22.36						
	TOTAL	535,580	580,070	182	42,161	125.73	0.70	180	-2	122	-60	-2
CHEROKEE,SPARTANBURG UNION	<65	315,460	329,830		5,033	14.42						
	+65	46,050	54,170		6,643	21.41						
	TOTAL	361,510	384,000	71	11,676	35.83	0.70	51	-20	81	10	10
CHESTER,LANCASTER YORK	<65	252,390	270,140		2,708	7.94						
	+65	32,210	39,340		189	0.63						
	TOTAL	284,600	309,480	20	2,897	8.57	0.70	12	-8	65	45	45
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	<65	197,620	206,180		3,481	9.95						
	+65	32,620	39,590		531	1.77						
	TOTAL	230,240	245,770	36	4,012	11.72	0.70	17	-19	52	16	16
FAIRFIELD,KERSHAW LEXINGTON,NEWBERRY RICHLAND	<65	627,490	662,290		38,897	112.48						
	+65	77,650	97,440		8,298	28.53						
	TOTAL	705,140	759,730	235	47,195	141.01	0.70	201	-34	160	-75	-34
DARLINGTON,FLORENCE MARION	<65	208,310	210,580		4,117	11.40						
	+65	29,470	35,730		2,117	7.03						
	TOTAL	237,780	246,310	35	6,234	18.43	0.70	26	-9	52	17	17
CHESTERFIELD,DILLON MARLBORO	<65	89,610	88,480		0	0.00						
	+65	12,110	14,170		0	0.00						
	TOTAL	101,720	102,650	8	0	0.00	0.70	0	-8	22	14	14

PSYCHIATRIC BED NEED

SERVICE AREA	AGE CAT	2008 POP	2015 POP	EXIST BEDS	2008 PDS	PROJ ADC	% OCC	BED NEED (USE)	+/-	BED NEED (SW)	+/-	BED NEED
CLARENDON,LEE,SUMTER	<65	146,760	149,790		0	0.00						
	+65	22,660	27,860		0	0.00						
	TOTAL	169,420	177,650	0	0	0.00	0.70	0	0	37	37	37
GEORGETOWN,HORRY	<65	270,580	289,440		7,266	24.74						
WILLIAMSBURG	+65	56,470	74,680		3,200	10.74						
	TOTAL	327,050	364,120	44	10,466	35.48	0.70	51	7	76	32	32
BAMBERG,CALHOUN	<65	109,670	110,010		2,214	6.08						
ORANGEBURG	+65	18,130	21,980		1,076	3.57						
	TOTAL	127,800	131,990	15	3,290	9.66	0.70	14	-1	28	13	13
ALLENDALE,BEAUFORT	<65	162,020	171,250		2,151	6.23						
HAMPTON,JASPER	+65	35,580	49,130		282	1.07						
	TOTAL	197,600	220,380	14	2,433	7.30	0.70	10	-4	46	32	32
BERKELEY,CHARLESTON	<65	562,410	578,890		31,002	87.43						
COLLETON,DORCHESTER	+65	78,650	104,130		4,274	15.50						
	TOTAL	641,060	683,020	152	35,276	102.93	0.70	147	-5	143	-9	-5
AIKEN,BARNWELL	<65	159,560	169,330		8,983	26.12						
	+65	25,320	31,130		1,417	4.77						
	TOTAL	184,880	200,460	29	10,400	30.89	0.70	44	15	42	13	15
	TOTAL			879				779	-100	982	103	208
STATE TOTAL	<65	3,640,450	3,814,500	0.000210	145,459	0.0416	0.03					
	+65	545,210	681,930		36,590	0.07	0.05					
	TOTAL	4,185,660	4,496,430		182,049	0.0453	0.03					

CHAPTER V

REHABILITATION FACILITIES

A rehabilitation facility is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program under competent professional supervision. A comprehensive physical rehabilitation service provides an intensive, coordinated team approach to care for patients with severe physical ailments and should be located where an extensive variety of professionals representing medical, psychological, social, and vocational rehabilitation evaluation and services are available. These beds are viewed as being comprehensive in nature and not limited only to a particular service or specialty. Patients with impairments such as spinal cord injury, traumatic brain injury, neuromuscular diseases, hip fractures, strokes, and amputations are typical clients. CMS identified 13 specific conditions for which facilities must treat 75% of their patients in order to qualify for Medicare reimbursement; however, legislation was signed in December 2007 that would freeze this threshold at 60% and allow co-morbid conditions to be counted.

Most general hospitals and other health care facilities offer physical rehabilitation services such as physical therapy, occupational therapy, speech therapy, or occupational therapy without the involvement of a formal interdisciplinary program. In addition, some hospitals have consolidated their rehabilitation services into a single unit to improve the coordination of care for acute patients in their facilities. These consolidations are intended to improve the quality of care for patients currently being treated in the facility and are not considered to be providing comprehensive physical rehabilitation services as defined in this section of the Plan.

Region	Facility	County	Beds	2008 Occupancy	
I	AnMed Health Rehab	Anderson	45	94.7%	*1*
I	Roger C. Peace	Greenville	53	56.6%	
I	St. Francis	Greenville	19	86.2%	
I	Mary Black	Spartanburg	18	84.9%	
II	Greenwood Rehab Hosp	Greenwood	34	67.6%	
II	HealthSouth Columbia	Richland	96	60.6%	
II	HealthSouth Rock Hill	York	46	88.6%	*2*
III	HealthSouth Florence	Florence	88	54.6%	
III	Carolinas Hospital	Florence	42	70.5%	
III	Waccamaw Community	Georgetown	43	81.8%	*3*
IV	Beaufort Memorial	Beaufort	14	53.9%	
IV	HealthSouth Charleston	Charleston	46	79.6%	
IV	Medical University	Charleston	0	---	*4*
IV	Roper Hospital	Charleston	52	82.2%	*5*
IV	RMC-Orangeburg/Calhoun	Orangeburg	24	37.5%	
IV	Coastal Carolina Med Ctr.	Jasper	10	48.1%	
		Total	630	64.9%	

1 CON to convert 3 nursing beds to rehab beds, for a total of 40 rehab beds 5/14/09, SC-09-25. CON issued for 5 additional rehab beds, for a total of 45, 7/8/09, SC-09-35. Licensed for 40 rehab beds 7/1/09; licensed for 45 beds 4/22/10.

2 CON issued 6/30/09 to add 6 rehab beds for a total of 46, SC-09-32.

3 CON issued 6/15/07 to add 14 beds for a total of 43, SC-07-22. Licensed for 43 beds 8/21/08.

4 CON issued 10/14/03 to convert their 25 rehabilitation beds to general acute beds. The beds were re-licensed as general acute beds on 1/30/08.

5 CON approved for 13 additional beds for a total of 52, 10/16/07, appealed. Case dismissed by ALJ Order 8/29/08. Licensed for 52 beds 10/28/09.

Certificate of Need Standards

1. The need for beds is calculated based on rehabilitation service areas.

2. The methodology takes the greater of the actual utilization of the facilities in the service area or the statewide average number of beds per 1,000 population to project need.

3. For service areas without existing rehabilitation units and related utilization data, 75% of the overall state use rate was used in the projections.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating Certificate of Need applications for this service:

a. Compliance with the Need Outlined in this Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Projected Revenues;
e. Projected Expenses;
f. Cost Containment; and
g. Resource Availability.

Rehabilitation facilities are now located throughout the state and are available within approximately sixty (60) minutes travel time for the majority of residents. Such facilities should be located where an extensive variety of health care professionals are available. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

Statewide Programs

The S.C. Vocational Rehabilitation Center operates a 30-bed facility in West Columbia to serve the vocational training needs of the disabled.

REHABILITATION BED NEED

SERVICE AREA	2008 POP	2015 POP	EXIST BEDS	2008 PDS	PROJ ADC	% OCC	BED NEED (USE)	+/-	BED NEED (SW)	+/-	NEED
ANDERSON,OCONEE	250,700	268,450	45	12,821	37.61	0.70	54	9	30	-15	9
GREENVILLE,PICKENS	535,580	580,070	72	16,977	50.38	0.70	72	0	66	-6	0
CHEROKEE,SPARTANBURG UNION	361,510	384,000	18	5,596	0.00	0.70	0	-18	44	26	26
CHESTER,LANCASTER YORK	284,600	309,480	40	12,977	38.66	0.70	55	15	35	-5	15
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	230,240	245,770	34	8,415	0.00	0.70	0	-34	28	-6	-6
FAIRFIELD,LEXINGTON NEWBERRY,RICHLAND	647,680	697,240	96	21,297	62.81	0.70	90	-6	79	-17	-6
CHESTERFIELD,DARLINGTON DILLON,FLORENCE,MARION MARLBORO,WILLIAMSBURG	376,390	385,660	130	28,422	79.79	0.70	114	-16	44	-86	-16
CLARENDON,KERSHAW LEE,SUMTER	226,880	240,140	0	0	0.00	0.70	0	0	27	27	27
GEORGETOWN,HORRY	290,160	327,420	43	9,220	28.50	0.70	41	-2	37	-6	-2
AIKEN,ALLENDALE,BAMBERG BARNWELL,CALHOUN ORANGEBURG	324,600	344,540	24	3,290	9.57	0.70	14	-10	39	15	15
BEAUFORT,HAMPTON,JASPER	185,680	208,290	24	4,523	13.90	0.70	20	-4	24	0	0
BERKELEY,CHARLESTON COLLETON,DORCHESTER	641,060	683,020	98	25,134	73.37	0.70	105	7	77	-21	7
STATE TOTAL	4,355,080	4,674,080	624	148,672	394.6		565	-59	530	-94	68
			0.1134								

CHAPTER VI

Alcohol and Drug Abuse Facilities

There are six types of licensed substance abuse treatment facilities in South Carolina. These are: outpatient facilities; social detoxification centers; freestanding medical detoxification facilities; residential treatment programs; inpatient treatment services, and narcotic treatment programs. These are defined as follows:

A. Outpatient Facilities:

Outpatient facilities provide treatment/care/services to individuals dependent upon or addicted to psychoactive substances and their families based on an individual treatment plan in a nonresidential setting. Outpatient treatment/care/services include assessment, diagnosis, individual and group counseling, family counseling, case management, crisis management services, and referral. Outpatient services are designed to treat the individual's level of problem severity and to achieve permanent changes in his or her behavior relative to the alcohol/drug abuse. These services address major lifestyle, attitudinal and behavioral issues that have the potential to undermine the goals of treatment or the individual's ability to cope with major life tasks without the non-medical use of alcohol or other drugs. The length and intensity of outpatient treatment varies according to the severity of the individual's illness and response to treatment. There are currently 67 licensed "Outpatient Facilities that Treat Individuals for Psychoactive Substance Abuse or Dependence" in South Carolina, with a total of 96 locations.

Certificate of Need Standards

A Certificate of Need is not required for outpatient facilities as described above.

B. Social Detoxification Facilities:

A service providing supervised withdrawal from alcohol or other drugs in which neither the client's level of intoxification nor physical condition is severe enough to warrant direct medical supervision or the use of medications to assist in withdrawal, but which maintains medical backup and provides a structured program of counseling, if appropriate, educational services, and referral for further rehabilitation. A social detoxification facility provides 24-hour-a-day observation of the client until discharge. Appropriate admission to a social detoxification facility shall be determined by a licensed or certified counselor and subsequently shall be authorized by a physician or other authorized healthcare provider in accordance with Section 1001.A. of Regulation 61-93, Standards for Licensing Facilities That Treat Individuals for Psychoactive Substance Abuse or Dependence. The services provided by Social detoxification facilities are described in Section 3102 of Regulation 61-93.

Certificate of Need Standards

A Certificate of Need is not required for a social detoxification facility.

C. Freestanding Medical Detoxification Facilities:

A short-term residential facility, separated from an inpatient treatment facility, providing for medically supervised withdrawal from psychoactive substance-induced intoxification, with the capacity to provide screening for medical complications of alcoholism and/or drug abuse, a structured program of counseling, if appropriate, and referral for further rehabilitation. Appropriate admission to a medical detoxification facility shall be determined by a licensed or certified counselor and subsequently should be authorized by a physician or other authorized healthcare provider in accordance with Section 1001.A. of Regulation 61-93. The services provided by these facilities are described in Section 3101 of the Regulation. Detoxification facilities are envisioned as being physically distinct from inpatient treatment facilities, although there are no prohibitions against an inpatient facility providing detoxification services to its clients as needed.

Morris Village, Patrick Harris, Byrnes Clinical, Holmesview and Palmetto Center are classified as statewide facilities with restricted admissions procedures and are not included in the inventory.

Facility	County	Beds
Charleston Center Subacute Detoxification Program	Charleston	16
The Phoenix Center Behavioral Health Services	Greenville	16
Lexington/Richland Alcohol & Drug Abuse/Detox Unit	Richland	16
Keystone Inpatient Services	York	10
Statewide Total		58

Certificate of Need Standards

1. Medical detoxification services are allocated by service area.

2. Facilities can be licensed for a maximum of 16 beds in order to meet federal requirements.

3. Because a minimum of 10 beds is needed for a medical detoxification program, a 10 bed unit may be approved in any service area without an existing detoxification unit, provided the applicant can document the need.

Relative Importance of Project Review Criteria

The following Project Review Criteria are considered to be the most important in evaluating Certificate of Need applications for this service:

1. Compliance with the Need Outlined in this Section of the Plan;
2. Distribution (Accessibility);
3. Projected Revenues;
4. Projected Expenses;
5. Ability of the Applicant to Complete the Project;
6. Cost Containment; and
7. Staff Resources.

Currently four freestanding medical detoxification facilities are located in the state, operated by local County Alcohol and Drug Abuse Agencies. There is a projected need for beds in almost every service area. Additional facilities are needed for the services to be accessible within sixty (60) minutes travel time for the majority of state residents. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

D. Residential Treatment Program Facilities:

RTPFs are 24-hour facilities offering an organized service in a residential setting, which is designed to improve the client's ability to structure and organize the tasks of daily living and recovery through planned clinical activities, counseling, and clinical monitoring in order to promote successful involvement or re-involvement in regular, productive, daily activity, and, as indicated, successful reintegration into family living. Residential treatment programs utilize a multi-disciplinary staff for clients whose biomedical and emotional/behavioral problems are severe enough to require residential services and who are in need of a stable and supportive environment to aid in their recovery and transition back into the community. Twenty-four hour observation, monitoring, and treatment shall be available.

Residential treatment programs provide the services described in Section 3000 of Regulation 61-93, Standards for Licensing Facilities That Treat Individuals for Psychoactive Substance Abuse or Dependence.

Certificate of Need Standards

A Certificate of Need is not required for a Residential Treatment Program.

E. Inpatient Treatment Facilities:

This is a short-term treatment service for persons who are in need of an organized intensive program of alcohol and/or drug rehabilitation, but who are without serious debilitating medical complications. These facilities may provide detoxification for their patients, as needed, in the inpatient treatment beds. These facilities are licensed either as a specialized hospital or as part of a hospital. Inpatient treatment facilities must comply with either Regulation 61-93, Standards for Licensing Facilities

That Treat Individuals for Psychoactive Substance Abuse or Dependence or Regulation 61-16, Standards for Licensing Hospitals and Institutional General Infirmaries.

Region	Facility	County	Beds	2008 Occupancy	
I	Carolina Center Behavioral Health	Greenville	13	102.0%	
I	Holmesview Center (Statewide)	Greenville	44	71.9%	*1*
II	Self Regional Healthcare	Greenwood	24	0.0%	
II	Springs Memorial	Lancaster	~~18~~ (0)	0.4%	*2*
II	Three Rivers Behavioral Health	Lexington	17	30.9%	*3*
II	Morris Village (Statewide)	Richland	163	80.0%	*1*
II	Palmetto Health Baptist	Richland	10	0.0%	*3*
II	Palmetto Richland Springs	Richland	10	94.0%	
II	William S. Hall (Statewide)	Richland	19	77.3%	*1*
III	Carolinas Hospital System	Florence	12	42.5%	
III	Palmetto Center (Statewide)	Florence	48	71.9%	*1*
III	Lighthouse Care Center Conway	Horry	14	83.3%	*4*
IV	Aiken Regional Medical Center	Aiken	18	26.5%	
IV	Medical University	Charleston	23	34.6%	
IV	Palmetto Lowcountry Behavioral	Charleston	10	99.1%	
IV	William J. McCord (Statewide)	Orangeburg	15	96.0%	*1*
Total (Does Not Include Statewide Beds)			151	46.1%	

1 Not Included in Bed Need Calculations.

2 CON approved 8/22/08 to convert the 18 substance abuse beds to general beds, appealed.

3 CONs issued 2/13/08 to exchange 10 substance abuse beds from Three Rivers for 10 psych beds from Palmetto Baptist. Beds licensed at Baptist and de-licensed at Three Rivers 7/21/08.

4 CON issued 1/25/10 for 6 additional beds for a total of 14.

Morris Village, Holmesview, W.J. McCord Adolescent, Palmetto Center and William S. Hall are classified as statewide facilities with restricted admissions procedures and are not included in the inventory of facilities and need calculations.

Certificate of Need Standards

1. Need projections are calculated by service area.

2. The bed need methodology takes the greater of the actual utilization of the facilities in the service area or the statewide beds per 1,000 population to project need.

3. For service areas without existing psychiatric units and related utilization data, the state use rate was used in the projections.

4. Because a minimum of 10 beds is needed for an inpatient program, a 10-bed unit may be approved in an area that does not have any existing beds provided the applicant can document the need.

5. Inpatient treatment facilities are physically distinct from freestanding detoxification centers. Applicants may not combine the bed need for freestanding detoxification with the bed need for inpatient treatment in order to generate a higher bed need for an inpatient facility. There are no prohibitions against an inpatient facility providing detoxification services to its clients as needed, but the bed need projections refer to two distinct treatment modes that cannot be commingled.

6. The establishment of a regional treatment center that serves more than a single service area may be proposed in order to improve access to care for patients in service areas that do not currently have such services available. Such a proposed center would be allowed to combine the bed need for a service area without existing services with another service area providing this other service area shows a need for additional beds. The applicant must document with patient origin data the historical utilization of the residents in the service area that is to be combined, or why it is in the best interest of these residents for their projected bed need to be used to used to form a regional treatment facility.

7. It is frequently impossible for a facility to totally predict or control short-term deviation in the number of patients with mixed psychiatric/addictive etiology to their illnesses. Therefore, in the case of facilities with licensed beds for both psychiatric and substance abuse treatment, the Department will allow deviations of up to 25% of the total number of licensed beds as swing beds to accommodate patients having diagnoses of both psychiatric and substance abuse disorders.

8. Due to the high use rate at William J. McCord and the lack of other adolescent services, it may be necessary for an additional adolescent state facility to be constructed to increase geographic accessibility to services. Any such proposal must have DAODAS support.

Relative Importance of Project Review Criteria

The following Project Review Criteria are considered to be the most important in evaluating Certificate of Need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Distribution (Accessibility);
c. Projected Revenues;
d. Projected Expenses;
e. Ability of the Applicant to Complete the Project;

INPATIENT BED NEED

SERVICE AREA	2008 POP	2015 POP	EXIST BEDS	PAT DAYS	PROJ ADC	% OCCUP	BED NEED (USE)	+/-	BED NEED (SW)	+/-	NEED
ANDERSON,OCONEE	202,560	219,700	0	1,993	5.92	0.70	8	8	8	8	8
GREENVILLE,PICKENS	432,470	474,060	13	4,852	14.57	0.70	21	8	18	5	8
CHEROKEE,SPARTANBURG UNION	289,010	310,610	0	0	9.48	0.70	14	14	12	12	14
CHESTER,LANCASTER,YORK	227,900	252,100	0	28	0.08	0.70	0	0	10	10	10
ABBEVILLE,EDGEFIELD GREENWOOD,LAURENS MCCORMICK,SALUDA	186,320	202,000	24	0	6.16	0.70	9	-15	8	-16	-15
FAIRFIELD,KERSHAW LEXINGTON,NEWBERRY RICHLAND	568,320	618,830	37	5,994	17.88	0.70	26	-11	24	-13	-11
DARLINGTON,FLORENCE MARION	188,930	197,680	12	1,867	5.35	0.70	8	-4	8	-4	-4
CHESTERFIELD,DILLON MARLBORO	79,900	81,100	0	0	2.47	0.70	4	4	3	3	4
CLARENDON,LEE,SUMTER	133,250	140,300	0	0	4.28	0.70	6	6	5	5	6
GEORGETOWN,HORRY WILLIAMSBURG	273,110	310,180	14	2,440	9.47	0.70	14	0	12	-2	0
BAMBERG,CALHOUN ORANGEBURG	102,750	106,840	0	0	3.26	0.70	5	5	4	4	5
ALLENDALE,BEAUFORT, HAMPTON,JASPER	163,700	187,350	0	0	5.72	0.70	8	8	7	7	8
BERKELEY,CHARLESTON, COLLETON,DORCHESTER	516,150	551,940	33	6,539	19.16	0.70	27	-6	21	-12	-6
AIKEN,BARNWELL	149,180	164,690	18	1,743	5.27	0.70	8	-10	6	-12	-10
STATE TOTAL	3,513,550	3,817,380	151	25,456	109.08		158	7	145	-6	17
STATE TOTAL	0.011138		0.0396								

f. Cost Containment; and
g. Staff Resources.

Currently, 11 inpatient treatment facilities are located in the state, not including state-operated facilities. There is a projected need for additional beds in some service areas. Services are accessible within sixty (60) minutes travel time for the majority of residents of the state. Current utilization and population growth are factored into the methodology for determining the need for additional beds. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

F. Narcotic Treatment Programs:

Narcotic treatment programs provide medications for the rehabilitation of persons dependent on opium, morphine, heroin or any derivative or synthetic drug of that group. Opioid maintenance therapy (OMT) is an umbrella term that encompasses a variety of pharmacologic and nonpharmacologic treatment modalities, including the therapeutic use of specialized opioid compounds such as methadone and buprenorphine to psychopharmacologically occupy opiate receptors in the brain, extinguish drug craving and thus establish a maintenance state. OMT is a separate service that can be provided in any level of care, as determined by the client's needs. Adjunctive nonpharmacologic interventions are essential and may be provided in the OMT clinic or through coordination with another addiction treatment provider. Narcotic treatment programs are described in Section 3200 of Regulation 61-93, Standards for Licensing Facilities That Treat Individuals for Psychoactive Substance Abuse or Dependence.

As of December 31, 2008, there were 4,313 clients currently being served by Methadone Treatment Centers.

Facility	County	2008 Clients During Year
Center for Behavioral Health South Carolina	Charleston	360
Center of Hope of Myrtle Beach	Horry	489
Charleston Center	Charleston	247
Columbia Metro Treatment Center	Lexington	462
Greenville Metro Treatment Center	Greenville	614
Recovery Concepts	Jasper	138
Southwest Carolina Treatment Center	Anderson	418
Spartanburg Treatment Associates	Spartanburg	635
Starting Point of Florence	Florence	473
York County Treatment Center	York	477
	Total	4,313

Certificate of Need Standards

1. A Certificate of Need is required for a methadone treatment facility.

2. A narcotic treatment program shall not operate within 500 feet of: a church, a public or private of elementary or secondary school, a boundary of any residential district, a public park adjacent to any residential district or the property line of a lot devoted to residential use.

3. Because clients usually must attend a Methadone Treatment Center 6 days per week to receive their dose of methadone, these centers should be located throughout the state. To improve accessibility, additional Methadone Treatment Centers should be developed in counties where none exist.

Relative Importance of Project Review Criteria

The following Project Review Criteria are considered to be the most important in evaluating Certificate of Need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Distribution (Accessibility);
c. Record of the Applicant;
d. Ability of the Applicant to Complete the Project.

The benefits of improved accessibility may outweigh the adverse effects of the duplication of this existing service.

CHAPTER VII

RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS

A Residential Treatment Facility for Children and Adolescents is operated for the assessment, diagnosis, treatment, and care of children and adolescents in need of mental health treatment. This means a child or adolescent up to age 21 who manifests a substantial disorder of cognitive or emotional process, which lessens or impairs to a marked degree that child's capacity either to develop or to exercise age-appropriate or age-adequate behavior. The behavior includes, but is not limited to, marked disorders of mood or thought processes, severe difficulties with self-control and judgment, including behavior dangerous to self or others, and serious disturbances in the ability to care for and relate to others.

These facilities provide medium to long-term care (6 months or longer). Treatment modalities are both medical and behavioral in nature. Some facilities contract with the Continuum of Care for Emotionally Disturbed Children to provide these services. The following facilities are currently licensed or approved as Residential Treatment Facilities:

Region	Facility	County	Beds	FY 2008 Occ. Rate
I	Excalibur Youth Services	Greenville	60	--- *1*
I	Marshall Pickens	Greenville	22	91.2%
I	Springbrook Behavioral	Greenville	68	88.5%
I	Avalonia Group Homes	Pickens	55	--- *2*
II	Three Rivers Behavioral	Lexington	20	94.2%
II	Three Rivers – Midlands	Lexington	59	96.9%
II	Directions (DMH)	Richland	37	55.4 %
II	New Hope Carolinas	York	150	--- 3
II	York Place Episcopal	York	40	75.4%
III	Palmetto Pee Dee	Florence	59	48.0%
III	Lighthouse of Conway	Horry	30	98.9% *4*
III	Willowglen Academy	Williamsburg	40	--- 5
IV	Palmetto Low Country	Charleston	32	95.3%
IV	Riverside at Windwood	Charleston	12	--- *6*
IV	Palmetto Pines Behavioral	Dorchester	60	92.6%
	Total (Does Not Include Directions)		707	85.6%

1 Licensed for 42 beds 12/31/08. CON issued 3/26/09 to add 18 beds for a total of 60, SC-09-15; licensed for 60 beds 6/26/09.

2 Licensed 9/18/08.

3 Licensed 11/20/08.

4 Number of licensed RTF beds increased from 16 to 30 10/29/09.

5 Licensed 3/20/09.
6 Licensed 3/18/10.

Services available at a minimum should include the following:

24-hour, awake supervision in a secure facility;

2. Individual treatment plans to assess the problems and determine specific patient goals;

3. Psychiatric consultation and professional psychological services for treatment supervision and consultation;

4. Nursing services, as required;

5. Regularly scheduled individual, group, and/or family counseling in keeping with the needs of each client;

6. Recreational facilities with an organized youth development program;

7. A special education program with a minimum program defined by the South Carolina Department of Education; and

8. Discharge planning including a final assessment of the patient's condition and an aftercare plan indicating any referrals to follow-up treatment and self-help groups.

Each facility shall have a written plan for cooperation with other public and private organizations, such as schools, social service agencies, etc., to ensure that each child under its care will receive comprehensive treatment. In addition, each facility shall have a written transfer agreement with one or more hospitals for the transfer of emergency cases when such hospitalization becomes necessary.

A proposal for Residential Treatment Facilities for Children and Adolescents should have letters of support from the Continuum of Care for Emotionally Disturbed Children, the SC Department of Social Services and the SC Department of Mental Health. Priority consideration will be given to those facilities that propose to serve highly aggressive and sexual offending youths and those with other needs as determined by these State agencies. In addition, smaller facilities may be given greater consideration than large facilities based on recommendations from the above agencies.

Certificate of Need Standards

1. Except in the case of high management group homes that received exemption from CON through Health and Human Services Budget Proviso 8.35, the establishment or expansion of an RTF requires a CON.

2. The applicant must document the need for the expansion of or the addition of an RTF based on the most current utilization data available. The existing resources must be considered and documentation presented as to why these resources are not adequate to meet the needs of the community.

3. For a new facility, the applicant must document where the potential patients for the facility will come from and where they are currently being served, to include the expected shift in patient volume from existing providers. For the expansion of an existing facility, the applicant must provide patient origin information on the current facility.

4. The applicant must document the potential impact that the proposed new RTF or expansion will have upon the existing service providers and referral patterns.

5. The applicant must provide a written commitment that the facility will provide services for indigent and charity patients at a percentage that is comparable to other health care facilities in the service area.

6. The applicant agrees to provide utilization data on the operation of the facility to the Department.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating certificate of need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Distribution (Accessibility);
c. Projected Revenues;
d. Projected Expenses;
e. Record of the Applicant;
f. Ability of the Applicant to Complete the Project;
g. Cost Containment; and
h. Staff Resources.

Residential treatment facility beds for children and adolescents are distributed statewide and are located within sixty (60) minutes travel time for the majority of residents of the State. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

CHAPTER VIII

CARDIOVASCULAR CARE

Cardiovascular diseases are the leading cause of death in the United States, accounting for more than 40% of all deaths. The total death rate for all cardiovascular diseases in South Carolina is the second highest in the country. Approximately one-third of all heart attacks are fatal. The amount of heart muscle damaged during a heart attack is an important determinant of whether patients live or die - and what their quality of life will be if they survive.

Diagnostic and therapeutic cardiac catheterizations and open heart surgery are tools in the treatment of heart disease. During a cardiac catheterization, a thin, flexible tube is inserted into a blood vessel in the arm or leg. The physician manipulates the tube to the chambers or vessels of the heart so that pressure measurements, blood samples and photographs can be taken. Injections of radioactive dye allow blockages or areas of weakness to appear on x-rays. Other diagnostic and therapeutic procedures may also be performed. Diagnostic catheterizations take approximately one and one-half hours to perform, while therapeutic catheterizations average three hours.

Percutaneous Coronary Intervention (PCI) is a therapeutic catheterization procedure used to treat occluded or partially occluded coronary arteries. A catheter with a balloon (PTCA) or a stent is inserted into the blood vessel and guided to the site of the constriction in the vessel. Due to the risk of arterial damage and the resulting need for immediate open heart surgery, elective PCI is contraindicated for institutions without an on-site open heart surgery program. Hospitals without an open heart surgery program shall be allowed to provide Emergent PCIs (Primary PCIs) only if they comply with all sections of Standard (8) of the Standards for Cardiac Catheterization.

During a Percutaneous Transluminal Coronary Angioplasty (PTCA), a balloon is inflated to flatten plaque against the artery wall and widen the narrowed artery. When a stent is used, an expandable metal coil is implanted at the site of a narrowing in a coronary artery to keep the vessel open; the framework buttresses the wall of the coronary artery. Newer drug-eluting stents are coated with an anti-rejection drug. It is anticipated that the increased use of stents may reduce the number of open heart surgeries performed.

Open heart surgery or intracardiac surgery refers to an operation performed on the heart or intrathoracic great vessels. Coronary Artery Bypass Graft (CABG) accounts for 80-85% of all open heart surgery cases, where veins are extracted from the patient and grafted to bypass a constricted section of coronary artery. The thoracic cavity is opened to expose the heart, which is stopped and the blood is recirculated and oxygenated during surgery by a heart-lung machine. Another option is "beating heart surgery," like Minimally Invasive Direct Coronary Artery Bypass (MIDCAB), where the surgeon operates through a smaller incision rather than breaking the breastbone to open the chest cavity and no bypass machine is used. The success rate for CABG surgery is high; the American Heart Association reports that 90% of bypass grafts still work 10 years after they are put into place. The mortality rate continues to decline, but CABG still carries significant risks.

Both cardiac catheterization and open heart surgery programs require highly skilled staffs and expensive equipment. Appropriately equipped and staffed programs serving larger populations are preferable to multiple, minimum population programs. Underutilized programs may reflect unnecessary duplication of services in an area, which may seriously compromise quality and safety of procedures and increase the cost of care. Optimal performance requires a caseload of adequate size to maintain the skills and efficiency of the staff. Cardiac catheterization laboratories should perform a minimum of 600 diagnostic equivalents per year (diagnostic catheterizations are weighted as 1.0 equivalents, therapeutic catheterizations as 2.0). Emergent PCI providers should perform a minimum of 36 PCIs annually; all other therapeutic cath providers should perform a minimum of 300 therapeutic caths annually. For pediatric catheterization and adult congenital cath labs, diagnostic catheterizations are weighted as 2.0 equivalents, therapeutic catheterizations as 3.0, EP studies as 2.0, biopsies performed after heart transplants as 1.0 equivalents, and adult concomitant congenital heart disease procedures performed in these labs are included in the utilization calculations. A minimum of 150 procedures per year is recommended; half of these should be on neonates or infants. There should be a minimum of 200 adult open heart surgery procedures performed annually per open heart surgery unit; improved results appear to appear in hospitals that perform a minimum of 350 cases annually. Pediatric open heart surgery units should perform 100 pediatric heart operations per year, at least 75 of which should be open heart surgery.

A. Status of South Carolina Providers:

1. Cardiac Catheterizations:

The Certificate of Need standards for cardiac catheterization require a minimum of 600 cardiac equivalents per laboratory annually within 3 years of initiation of service. There are 31 facilities approved to provide cardiac catheterization services in fixed laboratories in South Carolina. Of the 30 facilities that have been offering cardiac caths for more than three years, 19 exceeded the minimum of 600 equivalents per lab in 2008. Baptist Easley Hospital, Beaufort Memorial, Bon Secours St. Francis Xavier, Carolina Pines, Conway Hospital, Loris Community Hospital, Mary Black Memorial, Palmetto Health Baptist, Regional Medical Center–Orangeburg/Calhoun, Springs Memorial, and Tuomey Hospital fell below the minimum. Kershaw County Medical Center was not fully operational for 3 years. There are two mobile cath labs approved in the state, at Colleton Medical Center and Chester Regional Medical Center. The number of diagnostic catheterizations performed statewide decreased from 37,668 in 2007 to 37,537 in 2008.

Sixteen hospitals with open heart surgery programs provide therapeutic caths. They should be performing a minimum of 300 therapeutic caths annually within three years of initiation of service. Of the programs that had been operational for three full years, all but Carolinas Hospital System and Hilton Head Regional Medical Center performed the minimum number in 2008. In addition, Baptist Easley Hospital, Georgetown Memorial Hospital, and Lexington Medical Center have received CONs to perform Emergent PCIs without open heart surgery back-up. The number of therapeutic catheterizations performed statewide decreased from 16,456 in 2007 to 15,740 in 2008.

MUSC is the only facility providing pediatric cardiac catheterizations in South Carolina. The standard recommends a minimum of 600 cardiac equivalents per year; MUSC performed 1,250 equivalents in 2008.

2. Open Heart Surgery:

Currently 16 open heart surgery programs have been approved for the general public in South Carolina, in addition to the Veterans Administration (VA) Hospital in Charleston. The number of open heart surgeries performed decreased from 5,264 in 2007 to 5,219 in 2008. A total of 35 open heart surgery suites were in operation in 2008. With a capacity of 500 surgeries per suite, the statewide capacity was 17,500 surgeries. The state average utilization rate of 29.8% equated to 149.1 surgeries per suite. Unused capacity remains in all programs in the state.

The Certificate of Need standard is for a facility to perform a minimum of 200 open heart surgeries per year per surgical suite within three years of initiation of service. Aiken Regional, Hilton Head Regional, Piedmont Medical Center, and Self Memorial performed less than the minimum in 2008. However, this minimum volume should not be interpreted as an optimal level of operation. Studies indicate that hospitals that perform a minimum of 350 total cases annually tend to have better outcomes than those that perform fewer cases. In 2008, only eight of the 16 programs performed more than 350 total surgeries.

MUSC is the only facility performing pediatric open heart surgery in South Carolina. National and state standards recommend a minimum of 100 pediatric heart operations per open heart surgical suite. MUSC has consistently exceeded this standard; in 2008, 215 pediatric open heart surgeries were performed there.

The Certificate of Need standards for Cardiac Catheterization and Open Heart Surgery follow.

B. Cardiac Catheterization:

1. Definitions:

"Cardiac Catheterization Procedure" is an invasive procedure where a thin, flexible catheter is inserted into a blood vessel; the physician then manipulates the free end of the catheter into the chambers or vessels of the heart. All activities performed during one clinical session, including angiocardiography, coronary arteriography, pulmonary arteriography, coronary angioplasty and other diagnostic or therapeutic measures and physiologic studies shall be considered one procedure.

"Comprehensive Catheterization Laboratory" means a dedicated room or suite of rooms in which both diagnostic and therapeutic catheterizations are performed. They are located only in hospitals approved to provide open heart surgery, although diagnostic laboratories are allowed to perform emergency therapeutic catheterizations in compliance with Standard 8 below.

"Diagnostic Catheterization" refers to a cardiac catheterization during which any or all of the following diagnostic procedures or measures are performed: Blood Pressure; Oxygen Content and Flow Measurements; Angiocardiography, Coronary Arteriography; and Pulmonary Arteriography. The following ICD-9-CM Procedure Codes refer to diagnostic catheterizations:

37.21 Right Heart Cardiac Catheterization
37.22 Left Heart Cardiac Catheterization
37.23 Combined Right and Left Heart Cardiac Catheterization

"Diagnostic Catheterization Laboratory" means a dedicated room in which only diagnostic catheterizations are performed.

"Percutaneous Coronary Intervention (PCI)" refers to a therapeutic procedure to relieve coronary narrowing, such as Percutaneous Transluminal Coronary Angioplasty (PTCA) or Coronary Stent Implantation.

"Therapeutic catheterization" refers to a PCI or cardiac catheterization during which, in addition to any diagnostic catheterization procedure, any or all of the following interventional procedures are performed: PTCA; Thrombolytic Agent Infusion; Directional Coronary Atherectomy; Rotational Atherectomy; Extraction Atherectomy; Coronary Stent Implants and Cardiac Valvuloplasty. The following ICD-9-CM Procedure Codes refer to therapeutic catheterizations:

00.66 Percutaneous Transluminal Coronary Angioplasty (PTCA) or Coronary Atherectomy
35.52 Repair of Atrial Septal Defect with Prothesis, Closed Technique
35.96 Percutaneous Valvuloplasty
36.07 Insertion of Drug Eluting Coronary Artery Stent(s)
36.09 Other Removal of Coronary Artery Obstruction
37.34 Excision or Destruction of Other Lesion or Tissue of Heart, Other Approach

2. Scope of Services:

The following services should be available in both adult and pediatric catheterization laboratories:

A. Each cardiac catheterization lab should be competent to provide a range of angiographic (angiocardiography, coronary arteriography, pulmonary arteriography), hemodynamic, and physiologic (cardiac output measurement, intracardiac pressure, etc.) studies. These facilities should be available in one laboratory so that the patient need not be moved during a procedure.

B. The lab should have the capability of immediate endocardiac catheter pacemaking in cardiac arrest, a crash cart, and defibrillator.

C. A full range of non-invasive cardiac/circulatory diagnostic support services, such as the following, should be available within the hospital:

1. Nuclear Cardiology
2. Echocardiography
3. Pulmonary Function Testing
4. Exercise Testing
5. Electrocardiography
6. Cardiac Chest X-ray and Cardiac Fluoroscopy
7. Clinical Pathology and Blood Chemistry Analysis
8. Phonocardiography
9. Coronary Care Units (CCUs)
10. Medical Telemetry/Progressive Care

D. Each applicant shall document plans for providing cardiac rehabilitation services to its patients or plans for establishing referral agreements with facilities offering cardiac rehabilitation services.

Cardiac catheterization studies for elective cases should be available at least 40 hours a week. All catheterization laboratories should have the capacity for rapid mobilization of the study team for emergency procedures 24 hours a day, 7 days a week. All facilities offering cardiac catheterization services should meet full accreditation standards for The Joint Commission (TJC) or similar accrediting body.

Certificate of Need Standards

1. The capacity of a fixed cardiac catheterization laboratory shall be 1,200 diagnostic equivalents per year. Adult diagnostic catheterizations (ICD-9-CM Procedure Codes 37.21, 37.22 and 37.23) shall be weighted as 1.0 equivalents, while therapeutic catheterizations (ICD-9-CM Procedure Codes 00.66, 35.52, 35.96, 36.06, 36.07, 36.09, and 37.34) shall be

weighted as 2.0 equivalents. For pediatric and adult congenital cath labs, diagnostic caths shall be weighted as 2.0 equivalents, therapeutic caths shall be weighted as 3.0 equivalents, electrophysiology (EP) studies shall be weighted as 2.0 equivalents, and biopsies performed after heart transplants shall be weighted as 1.0 equivalents. The capacity of mobile cardiac catheterization labs will be calculated based on the number of days of operation per week.

2. The service area for a diagnostic catheterization laboratory is defined as all facilities within 45 minutes one way automobile travel time; for comprehensive cardiac catheterization laboratories the service area is all facilities within 60 minutes one way automobile travel time; a pediatric cardiac program should serve a population encompassing at least 30,000 births per year, or roughly two million people.

3. New diagnostic cardiac catheterization services, including mobile services, shall be approved only if all existing labs in the service area have performed at a combined use rate of 80% (960 equivalents per laboratory) for the most recent year;

4. An applicant for a fixed diagnostic service must project that the proposed service will perform a minimum of 600 diagnostic equivalent procedures annually within three years of initiation of services, without reducing the utilization of the existing diagnostic catheterization services in the service area below 80% of capacity.

5. An applicant for a mobile diagnostic catheterization laboratory must be able to project a minimum of 120 diagnostic equivalents annually for each day of the week that the mobile lab is located at the applicant's facility by the end of the third year following initiation of the service, without reducing the utilization of the existing diagnostic catheterization services in the service area below 80% of capacity (i.e. an applicant wishing to have a mobile cath lab 2 days per week must project a minimum of 240 equivalents at the applicant's facility by the end of the third year of operation). In addition:

   A. The applicant must document that the specific mobile unit utilized by the vendor will perform a combined minimum of 600 diagnostic equivalents per year;

   B. The applicant must include vendor documentation of the complication rate of the mobile units operated by the vendor; and

   C. If an application for a mobile lab is approved and the applicant subsequently desires to change vendors, the Department must approve such change in order to insure that appropriate minimum utilization can be documented.

6. Expansion of an existing diagnostic cardiac catheterization service shall only be approved if the service has operated at a minimum use rate of 80% of capacity (i.e. 960 equivalents per laboratory) for each of the past two years and can project a minimum of 600 procedures per year on the additional equipment within three years of its implementation.

7. Comprehensive cardiac catheterization laboratories, which perform diagnostic catheterizations, PCI and other therapeutic procedures, shall only be located in hospitals that provide open heart surgery. The ACC/AHA/SCAI Writing Committee continues to support the recommendation that elective PCI should not be performed in facilities without on-site cardiac surgery, due to the risk of arterial damage and subsequent need for emergency bypass surgery. Diagnostic cardiac catheterization laboratories, which serve to detect and identify defects in the great arteries or veins of the heart or abnormalities in the heart structure, shall be allowed to perform emergency PCI provided they comply with all sections of standard 8.

8. The provision of emergency PCI (Primary PCI) at a hospital without an on-site comprehensive catheterization laboratory and an open heart surgery program requires a Certificate of Need. This application shall be approved only if all of the following criteria are met:

A. Therapeutic catheterizations must be limited to Percutaneous Coronary Interventions (PCIs) performed only in emergent circumstances (Primary PCIs). Elective PCI may not be performed at institutions that do not provide on-site cardiac surgery.

B. The applicant has a diagnostic catheterization laboratory that has performed a minimum of 600 diagnostic catheterizations for the most recent year of data.

C. The hospital must acquire an intra-aortic balloon pump (IABP) dedicated solely to this purpose.

D. The chief executive officer of the hospital must sign an affidavit assuring that the criteria listed below are and will continue to be met at all times.

E. An application shall be approved only if it is consistent with the criteria from *Smith et al., ACC/AHA/SCAI 2005 Guideline Update for Percutaneous Coronary Intervention: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (ACC/AHA/SCAI Writing Committee to Update the 2001 Guidelines for Percutaneous Coronary Intervention)* and the *2007 Focused Update* of the guidelines. The complete guidelines can be found at:
www.acc.org/clinical/guidelines/percutaneous/update/index.pdf

1. Criteria for the Performance of Emergency (Primary) PCI

    a. The physicians must be experienced interventionalists who regularly perform elective intervention at a surgical center (75 cases/year). The institution must perform a minimum of 36 primary PCI procedures per year.

b. The nursing and technical catheterization laboratory staff must be experienced in handling acutely ill patients and comfortable with interventional equipment. They must have acquired experience in dedicated interventional laboratories at a surgical center. They participate in a 24-hour, 365-day call schedule.

c. The catheterization laboratory itself must be well-equipped, with optimal imaging systems, resuscitative equipment, intra-aortic balloon pump (IABP) support, and must be well-stocked with a broad array of interventional equipment.

d. The cardiac care unit nurses must be adept in hemodynamic monitoring and IABP management.

e. The hospital administration must fully support the program and enable the fulfillment of the above institutional requirements.

f. There must be formalized written protocols in place for immediate (within one hour) and efficient transfer of patients to the nearest cardiac surgical facility that are reviewed/tested on a regular (quarterly) basis.

g. Primary (emergency) intervention must be performed routinely as the treatment of choice around the clock for a large proportion of patients with acute myocardial infarction (AMI) to ensure streamlined care paths and increased case volumes.

h. Case selection for the performance of primary (emergency) angioplasty must be rigorous. Criteria for the types of lesions appropriate for primary (emergency) angioplasty and for the selection for transfer for emergent aortocoronary bypass surgery are shown in Section E.2.

i. There must be an ongoing program of outcomes analysis and formalized periodic case review. Institutions should participate in a three-to-six month period of implementation during which time development of a formalized primary PCI program is instituted that includes establishing standards, training staff, detailed logistic development, and creation of a quality assessment and error management system.

2. Patient Selection Guidelines

a. Avoid intervention in hemodynamically stable patients with:

1) Significant (60%) stenosis of an unprotected left main (LM) coronary artery upstream from an acute occlusion in the left coronary system that might be disrupted by the angioplasty catheter.
2) Extremely long or angulated infarct-related lesions with TIMI grade 3 flow.

3) Infarct-related lesions with TIMI grade 3 flow in stable patients with 3-vessel disease.
4) Infarct-related lesions of small or secondary vessels.
5) Lesions in other than the infarct artery.

b. Transfer emergent aortocoronary bypass surgery patients after PCI of occluded vessels if high-grade residual left main or multi-vessel coronary disease and clinical or hemodynamic instability are present, preferably with intra-aortic balloon pump support

9. New comprehensive cardiac catheterization services shall be approved only if the following conditions are met:

A. All existing comprehensive cardiac catheterization facilities in the service area performed a minimum of 300 therapeutic catheterizations and performed at a combined use rate of 80 percent in the most recent year (i.e. 960 equivalents per laboratory); and

B. An applicant must project that the proposed service will perform a minimum of 300 therapeutic catheterization procedures annually within three years of initiation of services, without reducing the combined use rate of the existing comprehensive catheterization programs in the service area below 80%.

10. Expansion of an existing comprehensive cardiac catheterization service shall be approved only if the service has operated at a minimum use rate of 80% of capacity (960 equivalents per lab) for each of the past two years and can project a minimum of 600 equivalents per year on the additional equipment within three years of its implementation. The 600 equivalents may consist of a combination of diagnostic and therapeutic procedures.

11. New pediatric cardiac catheterization services shall be approved only if the following conditions are met:

A. All existing facilities have performed at a combined use rate of 80% of capacity for the most recent year; and

B. An applicant must project that the proposed service will perform a minimum of 600 diagnostic equivalent procedures annually within three years of initiation of services.

12. Expansion of an existing pediatric cardiac catheterization service shall only be approved if the service has operated at a minimum use rate of 80% of capacity (960 equivalents) for each of the past two years and can project a minimum of 600 equivalents per year on the additional equipment within three years of its implementation.

13. Documentation of need for the proposed service:

A. The applicant shall provide epidemiologic evidence of the incidence and prevalence of conditions for which diagnostic, comprehensive or pediatric catheterization is appropriate within the proposed service area, to include the number of potential candidates for these procedures;

B. The applicant shall project the utilization of the service and the effect of its projected utilization on other cardiac catheterization services within its service area, to include:

1. The number of patients of the applicant hospital who were referred to other cardiac catheterization services in the preceding three years and the number of those patients who could have been served by the proposed service;

2. The number of additional patients, if any, who will be generated through changes in referral patterns, recruitment of specific physicians, or other changes in circumstances. The applicant shall document the services, if any, from which these patients will be drawn; and

3. Existing and projected patient origin information and referral patterns for each cardiac catheterization service serving patients from the area proposed to be served shall be provided.

14. Both fixed and mobile diagnostic cardiac catheterization laboratories must provide a written agreement with at least one hospital providing open heart surgery, which states specified arrangements for referral and transfer of patients, to include:

A. Criteria for referral of patients on both a routine and an emergency back-up basis;

B. Regular communications between cardiologists performing catheterizations and surgeons to whom patients are referred;

C. Acceptability of diagnostic results from the cardiac catheterization service to the receiving surgical service to the greatest extent possible to prevent duplication of services; and

D. Development of linkages with the receiving institution's peer review mechanism.

15. The application shall include standards adopted or to be adopted by the service, consistent with current medical practice as published by clinical professional organizations, such as the American College of Cardiology or the American Heart Association, defining high-risk procedures and patients who, because of their conditions, are at high risk. For diagnostic catheterization laboratories, this description of patient selection criteria shall include referral arrangements for high-risk patients. For comprehensive laboratories, these high-risk

procedures should only be performed with open heart surgery back-up. The cardiac team must be promptly available and capable of successfully operating on unstable acute ischemic patients in an emergency setting.

16. Cardiac catheterization services should be staffed by a minimum of two physicians licensed by the State of South Carolina who possess the qualifications specified by the governing body of the facility. Protocols should be established that govern initial and continuing granting of clinical staff privileges to physicians to perform diagnostic, therapeutic and/or pediatric catheterizations. In addition, standards should be established to assure that each physician using the service would be involved in adequate numbers of applicable types of cardiac catheterization procedures to maintain proficiency.

17. The Department encourages all applicants and providers to share their outcomes data with appropriate registries and research studies designed to improve the quality of cardiac care.

Quality

No ideal rate has been established for PTCA [PCI] and the rates vary widely by area and population group. The IQI considers PCI to be a potentially over-used procedure and a more average rate equates to better quality care. However, high PCI utilization has not been shown to necessarily be associated with higher rates of inappropriate utilization. Source: http://www.qualityindicators.ahrq.gov/downloads/iqi/iqi_guide_v31.pdf

Every minute saved is important in treating heart attacks. According to guidelines established by the ACC/AHA in 2004, facilities that provide primary PCI for acute MI patients should initiate the PCI within 90 minutes from the time of hospital arrival. The ACC created the D2B Alliance in 2006 to advise hospitals on how to reduce the door-to-balloon time. The national rate has improved from approximately 50% in 2005 to nearly 90% as of December 2009. For the first quarter of 2009, the state average was 89.93%. For the hospitals for which data were available, Greenville Memorial had the highest rate (99.3%) and Piedmont Medical Center had the lowest rate (81.0%). Source: http://whynotthebest.org/reports/view

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating certificate of need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Projected Revenues;
e. Projected Expenses;

f. Ability of the Applicant to Complete the Project;
g. Financial Feasibility;
h. Staff Resources; and
i. Adverse Effects on Other Facilities.

The Department finds that:

(1) Diagnostic catheterization services are available within forty-five (45) minutes and therapeutic catheterization services within ninety (90) minutes travel time for the majority of South Carolina residents;

(2) Significant cardiac catheterization capacity exists in most areas of the State; and

(3) The preponderance of the literature on the subject indicates that a minimum number of procedures are recommended per year in order to develop and maintain physician and staff competency in performing these procedures.

The benefits of improved accessibility will not outweigh the adverse effects of duplication in evaluating Certificate of Need applications for this service.

CARDIAC CATHETERIZATION PROCEDURES

REGION/FACILITY		# CATH LABS	FY06 ADULT DIAG	FY06 ADULT THERP	FY06 ADULT TOTAL	FY06 PED DIAG	FY06 PED THERP	FY06 PED TOTAL	FY07 ADULT DIAG	FY07 ADULT THERP	FY07 ADULT TOTAL	FY07 PED DIAG	FY07 PED THERP	FY07 PED TOTAL	FY08 ADULT DIAG	FY08 ADULT THERP	FY08 ADULT TOTAL	FY08 PED DIAG	FY08 PED THERP	FY08 PED OTHER	FY08 PED TOTAL
I																					
ANMED HEALTH MEDICAL CENTER	1	4	1,976	1,134	3,110				1,971	1,305	3,276				1,993	1,222	3,215				
GREENVILLE MEMORIAL HOSPITAL		7	2,864	2,121	4,985				2,118	3,373	5,491				3,163	2,467	5,630				
SAINT FRANCIS - DOWNTOWN	2	4	1,307	625	1,932				1,471	762	2,233				1,906	1,052	2,958				
OCONEE MEMORIAL HOSPITAL		1	993		993				700		700				882		882				
PALMETTO BAPTIST MED CTR-EASLEY	3	1	567		567				497		497				474		474				
MARY BLACK MEMORIAL		1	213		213				212		212				154		154				
SPARTANBURG REGIONAL MEDICAL CTR		4	3,254	1,130	4,384				3,217	1,013	4,230				2,283	1,011	3,294				
TOTAL REGION I		22	11,174	5,010	16,184				10,186	6,453	16,639				10,855	5,752	16,607				
II																					
CHESTER REGIONAL MEDICAL CENTER		MOBILE	73		73				118		118				116		116				
SELF REGIONAL HEALTHCARE		2	1,224	333	1,557				1,151	323	1,474				1,324	408	1,732				
KERSHAWHEALTH		1			0						0				367		367				
SPRINGS MEMORIAL HOSPITAL		1	382		382				320		320				544		544				
LEXINGTON MEDICAL CENTER	4	1	1,355	19	1,374				1,253	12	1,265				1,128	3	1,131				
PALMETTO HEALTH BAPTIST		1	365		365				269		269				275		275				
PALMETTO HEALTH RICHLAND		4	2,898	1,039	3,937				3,197	1,157	4,354				3,208	1,170	4,378				
PROVIDENCE HOSPITAL		6	3,924	3,039	6,963				3,583	2,723	6,306				3,460	2,700	6,160				
PIEDMONT MEDICAL CENTER		3	1,673	828	2,501				1,521	798	2,319				1,595	864	2,459				
SOUTH CAROLINA HEART CENTER	5	2	2,318		2,318				2,172		2,172				1,829		1,829				
TOTAL REGION II		22	14,212	5,258	19,470				13,584	5,013	18,597				13,846	5,145	18,991				
III																					
CAROLINA PINES REGIONAL MEDICAL CTR		1	322		322				146		146				61		61				
CAROLINAS HOSPITAL SYSTEM		2	1,188	268	1,456				1,082	246	1,328				1,155	263	1,418				
MCLEOD REGIONAL MEDICAL CENTER		4	1,868	723	2,591				1,859	776	2,635				1,823	760	2,583				
GEORGETOWN MEMORIAL HOSPITAL		1	915	44	959				951	58	1,009				868	59	927				
CONWAY HOSPITAL		1	763		763				765		765				557		557				
GRAND STRAND REGIONAL MED CTR	6	3	845	595	1,440				1,177	524	1,701				862	580	1,442				
LORIS COMMUNITY HOSPITAL		1	318		318				301		301				238		238				
TUOMEY		1	331		331				311		311				307		307				
TOTAL REGION III		14	6,550	1,630	8,180				6,592	1,604	8,196				5,871	1,662	7,533				

IV	# CATH LABS	FY06 ADULT DIAG	ADULT THERP	ADULT TOTAL	PED	FY07 ADULT DIAG	ADULT THERP	ADULT TOTAL	PED DIAG	PED THERP	PED TOTAL	FY08 ADULT DIAG	ADULT THERP	ADULT TOTAL	PED DIAG	PED THERP	PED OTHER	PED TOTAL
AIKEN REGIONAL MEDICAL CENTER	1	908	447	1,355		710	511	1,221				608	500	1,108				
BEAUFORT MEMORIAL HOSPITAL	1	397		397		485		485				386		386				
HILTON HEAD HOSPITAL	2	501	233	734		685	227	912				624	235	859				
COLLETON MEDICAL CENTER	MOBILE			0		0		0				0		0				
BON SECOURS ST. FRANCIS XAVIER	1	21		21		0		0				0		0				
MUSC MEDICAL CENTER	5	1,833	732	2,565	253	1,617	1,334	2,951	215	119	334	1,435	1,038	2,473	232	217	93	542
ROPER HOSPITAL	3	2,055	736	2,791		1,898	942	2,840				1,979	992	2,971				
TRIDENT MEDICAL CENTER	2	1,686	503	2,189		1,456	372	1,828				1,417	392	1,809				
REG MED CTR ORANGEBURG-CALHOUN	1	691		691		455		455				474		474				
RALPH HENRY VA MED CTR CHARLESTON	(1)					(440)	(302)	(742)										
TOTAL REGION IV	17	8,092	2,651	10,743	253	7,306	3,386	10,692	215	119	334	6,923	3,157	10,080	232	217	93	542
STATEWIDE TOTALS	75	40,028	14,549	54,577	253	37,668	16,456	54,124	215	119	334	37,495	15,716	53,211	232	217		542

C. Open Heart Surgery:

1. Definitions:

"Capacity" means the number of open heart surgery procedures that can be accommodated in an open heart surgery unit in one year.

"Open Heart Surgery" refers to an operation performed on the heart or intrathoracic great vessels. It is identified by the following ICD-9-CM procedure codes: 35.10-35.14, 35.20-35.28, 35.31-35.35, 35.39, 35.41-35.42, 35.50-35.51, 35.53-35.54, 35.60- 35.63, 35.70-35.73, 35.81-35.84, 35.91-35.95, 35.98-35.99, 36.03, 36.09, 36.10-36.16, 36.19, 36.2, 36.91, 36.99, 37.10-37.11, 37.32-37.33.

An "Open Heart Surgery Unit" is an operating room or suite of rooms equipped and staffed to perform open heart surgery procedures; such designation does not preclude its use for other related surgeries, such as vascular surgical procedures. A hospital with an open heart surgery program may have one or more open heart surgery units.

"Open Heart Surgical Procedure" means an operation performed on the heart or intrathoracic great vessels within an open heart surgical unit. All activities performed during one clinical session shall be considered one procedure.

"Open Heart Surgical Program" means the combination of staff, equipment, physical space and support services which is used to perform open heart surgery. Adult open heart surgical programs should have the capacity to perform a full range of procedures, including:

1. repair/replacement of heart valves
2. repair of congenital defects
3. cardiac revascularization
4. repair/reconstruction of intrathoracic vessels
5. treatment of cardiac traumas.

In addition, open heart programs must have the ability to implement and apply circulatory assist devices such as intra-aortic balloon and prolonged cardiopulmonary partial bypass.

2. Scope of Services:

A range of non-invasive cardiac and circulatory diagnostic services should be available within the hospital, including the following:

a. services for hematology and coagulation disorders;
b. electrocardiography, including exercise stress testing;
c. diagnostic radiology;
d. clinical pathology services which include blood chemistry and blood gas analysis;

e. nuclear medicine services which include nuclear cardiology;
f. echocardiography;
g. pulmonary function testing;
h. microbiology studies;
i. Coronary Care Units (CCU's);
j. medical telemetry/progressive care; and
k. perfusion.

Backup physician personnel in the following specialties should be available in emergency situations:

a. Cardiology;
b. Anesthesiology;
c. Pathology;
d. Thoracic Surgery; and
e. Radiology.

Each applicant shall document plans for providing cardiac rehabilitation services to its patients or plans for establishing referral agreements with facilities offering cardiac rehabilitation services.

Adult open heart surgery services should be available within 60 minutes one-way automobile travel for 90% of the population. A pediatric cardiac surgical service should provide services for a minimum service area population with 30,000 live births, or roughly 2 million people. Open heart surgery for elective procedures should be available at least 40 hours per week, and elective open heart surgery should be accessible with a waiting time of no more than two weeks. All facilities providing open heart surgery must conform with local, state, and federal regulatory requirements and should meet the full accreditation standards for The Joint Commission (TJC), if the facility is TJC accredited.

Certificate of Need Standards

1. The establishment or addition of an open heart surgery unit requires Certificate of Need review, as this is considered a substantial expansion of a health service.

2. Comprehensive cardiac catheterization laboratories shall only be located in hospitals that provide open heart surgery. The lack of a formal cardiac surgical program within the institution is an absolute contraindication for therapeutic catheterizations due to the risk of arterial damage and subsequent need for emergency bypass surgery.

3. The capacity of an open heart surgery program is 500 open heart procedures per year for the initial open heart surgery unit and each additional dedicated open heart surgery unit (i.e., each operating room equipped and staffed to perform open heart surgery has a maximum capacity of 500 procedures annually).

4. There should be a minimum of 200 adult open heart surgery procedures performed annually per open heart surgery unit within three years after initiation in any institution in which open heart surgery is performed for adults. In institutions performing pediatric open heart surgery there should be a minimum of 100 pediatric heart operations per open heart surgery unit; at least 75 should be open heart surgery.

5. New open heart surgery services shall be approved only if the following conditions are met:

   A. Each existing unit in the service area (defined as all facilities within 60 minutes one way automobile travel, excluding any facilities located in either North Carolina or Georgia) is performing an annual minimum of 350 open heart surgery procedures per open heart surgery unit for adult services (70 percent of functional capacity). The standard for pediatric open heart cases in pediatric services is 130 procedures per unit. An exception to this requirement may be authorized should an applicant meet both of the following criteria:

      1. There are no open heart surgery programs located in the same county as the applicant; and

      2. The proposed facility currently offers cardiac catheterization services and provided a minimum of 1,200 diagnostic equivalents in the previous year of operation.

   B. An applicant must project that the proposed service will perform a minimum of 200 adult open heart surgery procedures annually per open heart surgery unit within three years after initiation (the standard for pediatric open heart surgery shall be 100 procedures annually per open heart surgery unit within three years after initiation):

      1. The applicant shall provide epidemiological evidence of the incidence and prevalence of conditions for which open heart surgery is appropriate within the proposed service area, to include the number of potential candidates for these procedures;

      2. The applicant shall provide an explanation of how the applicant projects the utilization of the service and the effect of its projected utilization on other open heart surgery services, including:

         a. The number of patients of the applicant hospital who were referred to other open heart surgery services in the preceding three years and the number of these patients who could have been served by the proposed service;

b. The number of additional patients, if any, who will be generated through changes in referral patterns, recruitment of specific physicians, or other changes in circumstances. The applicant shall document the services, if any, from which these patients will be drawn; and

c. The existing and projected patient origin information and referral patterns for each open heart surgery service serving patients from the area proposed to be served shall be provided.

6. No new open heart surgery programs shall be approved if the new program will cause the annual caseload of other programs within the proposed service area to drop below 350 adult procedures or 130 pediatric procedures per open heart surgery unit.

7. Expansion of an existing open heart surgery service shall only be approved if the service has operated at a minimum use rate of 70 percent of capacity for each of the past two years and can project a minimum of 200 procedures per year in the new open heart surgery unit. The applicant shall document the other service providers, if any, from which these additional patients will be drawn.

8. The application shall include standards adopted or to be adopted by the service, consistent with current medical practice as published by clinical professional organizations, such as the American College of Cardiology or the American Heart Association, defining high-risk procedures and patients who, because of their conditions, are at high risk and shall state whether high-risk cases are or will be performed or high-risk patients will be served.

9. Open heart surgery services should be staffed by a minimum of two physicians licensed by the State of South Carolina who possess the qualifications specified by the governing body of the facility. Protocols should be established that govern initial and continuing granting of clinical staff privileges to physicians to perform open heart surgery and therapeutic cardiac catheterizations. In addition, standards should be established to assure that each physician using the service will be involved in adequate numbers of applicable types of open heart surgery and therapeutic cardiac catheterizations to maintain proficiency.

10. The open heart surgery service will have the capability for emergency coronary artery surgery, including:

A. Sufficient personnel and facilities available to conduct the coronary artery surgery on an immediate, emergency basis, 24 hours a day, 7 days a week;

B. Location of the cardiac catheterization laboratory(ies) in which therapeutic catheterizations will be performed near the open heart surgery operating rooms; and

C. A predetermined protocol adopted by the cardiac catheterization service governing the provision of PTCA and other therapeutic or high-risk cardiac catheterization procedures or the catheterization of patients at high risk and defining the plans for the patients' emergency care. These high-risk procedures should only be performed with open heart surgery backup. The cardiac team must be promptly available and capable of successfully operating on unstable acute ischemic patients in an emergency setting.

11. The Department encourages all applicants and providers to share their outcomes data with appropriate registries and research studies designed to improve the quality of cardiac care.

Quality

Volume is a proxy measure for quality. Higher volumes have been associated with better outcomes although some low-volume hospitals have very good outcomes. There is a potential for variation in CABG rates between area populations.

The DHEC Hospital Acquired Infections (HAI) report includes a standardized Surgical Site Infection (SSI) ratio for Coronary Artery Bypass Grafts. All South Carolina open heart surgery providers should be lower than or not different than their statistically expected ratios. For 2009, Palmetto Health Richland and Providence Hospital had statistically significantly lower SSIs than projected; all other providers were within their expected ranges. Source: http://www.scdhec.gov/health/disease/hai/docs/Table%201.%20Coronary%20Artery%20Bypass%20(Chest%20and%20Donor%20Incision).pdf

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating Certificate of Need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Projected Revenues;
e. Projected Expenses;
f. Ability of the Applicant to Complete the Project;
g. Financial Feasibility;
h. Cost Containment;
i. Staff Resources; and
j. Adverse Effects on Other Facilities.

The Department makes the following findings:

1. Open heart surgery services are available within sixty (60) minutes travel time for the majority of residents of South Carolina;

2. Based upon the standards cited above, most of the open heart surgery providers are currently utilizing less than the functional capability (i.e. 70% of maximum capacity) of their existing surgical suites;

3. The preponderance of the literature on the subject indicates that a minimum number of procedures is recommended per year in order to develop and maintain physician and staff competency in performing these procedures; and

4. Increasing geographic access may create lower volumes in existing programs causing a potential reduction in quality and efficiency, exacerbate existing problems regarding the availability of nursing staff and other personnel, and not necessarily reduce waiting time since other factors (such as the referring physician's preference) would still need to be addressed.

5. Research has shown a positive relationship between the volume of open heart surgeries performed annually at a facility and patient outcomes. Thus, the Department establishes minimum standards that must be met by a hospital in order to provide open heart surgery. Specifically, a hospital is required to project a minimum of 200 open heart surgeries annually within three years of initiation of services. This number is considered to be the minimum caseload required to operate a program that maintains the skill and efficiency of hospital staff and reflects an efficient use of an expensive resource. It is in the public's interest that facilities achieve their projected volumes.

6. The State Health Planning Committee recognizes the important correlation between volume and proficiency. The Committee further recognizes that the number of open heart surgery cases is decreasing and that maintaining volume in programs is very important to the provision of quality care to the community.

The benefits of improved accessibility will not outweigh the adverse effects of duplication in evaluating Certificate of Need applications for this service.

OPEN HEART SURGERIES

REGION/FACILITY	# OPEN HEART UNITS	FY06 ADULTS	FY06 PEDS	FY07 ADULTS	FY07 PEDS	FY08 ADULTS	FY08 PEDS
I							
ANMED HEALTH MEDICAL CENTER	2	265		225		226	
GREENVILLE MEMORIAL MED CTR	4	710		646		583	
ST FRANCIS - DOWNTOWN	2	226		305		347	
SPARTANBURG REGIONAL MED CTR	2	383		433		432	
TOTAL REGION I	10	1,584		1,609		1,588	
II							
SELF REGIONAL HEALTHCARE	2	132		139		116	
PALMETTO HEALTH RICHLAND	2	450		436		435	
PROVIDENCE HOSPITAL	4	826		843		784	
PIEDMONT MEDICAL CENTER	2	166		149		164	
TOTAL REGION II	10	1,574		1,567		1,499	
III							
CAROLINAS HOSPITAL SYSTEM	2	247		202		201	
MCLEOD REGIONAL MEDICAL CENTER	3	309		350		429	
GRAND STRAND REGIONAL MED CTR	2	404		439		392	
TOTAL REGION III	7	960		991		1,022	
IV							
AIKEN REGIONAL MEDICAL CTR	1	91		101		65	
HILTON HEAD HOSPITAL	1	12		53		55	
MUSC MEDICAL CENTER	3	530	308	314	212	376	215
ROPER HOSPITAL	2	451		427		409	
TRIDENT REGIONAL MED CTR	1	236		202		205	
VA HOSPITAL (CHARLESTON)	1			(110)			
TOTAL REGION IV	9	1,320	308	1,097	212	1,110	215
STATEWIDE TOTALS	35	5,438	308	5,264	212	5,219	215

CHAPTER IX

MEGAVOLTAGE RADIOTHERAPY & RADIOSURGERY

Cancer is a group of many related diseases, all involving out-of-control growth and spread of abnormal cells. These cells accumulate and form tumors that invade and destroy normal tissue. Cancer is the second leading cause of death, both nationally and in South Carolina, accounting for approximately 22% of all deaths. According to the South Carolina Central Cancer Registry (SCCCR), there were 21,532 new cases of cancer diagnosed in South Carolina in 2006 and 9,063 cancer deaths. Different types of cancer vary in their rates of growth, patterns of spread and responses to different types of treatment. The overall five-year survival rate is approximately 62%.

Megavoltage radiation has been utilized for decades as a standard modality for cancer treatment. It is best known as Radiation Therapy, but is also called Radiotherapy, X-Ray Therapy, or Irradiation. It kills cancer cells and shrink tumors by damaging their genetic material, making it impossible for these cells to continue to grow and divide. Approximately 50% of all cancer patients receive radiation therapy at some time during their illness, either alone or in combination with surgery or chemotherapy. It can be used as a therapeutic treatment (to attempt to cure the disease), a prophylactic treatment (to prevent cancer cells from growing in the area receiving the radiation) or as a palliative treatment (to reduce suffering and improve quality of life when a cure is not possible).

Beams of ionizing radiation are aimed to meet at a specific point and delivery radiation to that precise location. The amount of radiation used is measured in "gray" (Gy) and varies depending on the type and stage of cancer being treated. Radiation damages both cancer cells and normal cells, so the goal is to damage as many cancer cells as possible, while limiting harm to nearby healthy tissue. A typical course of treatment lasts for two to 10 weeks, depending on the type of cancer and the treatment goal. The relevant CPT Procedure codes are: 77371-77373, 77401-77404, 77406-77409, 77411-77414, 77416, 77418, 77432 and 77470.

1. Definitions:

There are varying types of radiation treatment and definitions are often used interchangeably. The following definitions apply:

Adaptive Radiation Therapy (ART): Patient setup and/or radiation delivery is evaluated and modified periodically during the treatment course based on imaging and dose measurements made prior to or during treatment.

Conformal Radiation Therapy (CRT): Since the target often has a complex shape, CT, MRI, or PET is used to create a 3-D image of the tumor. Using the image, the computer designs the radiation beams to be shaped exactly (conform) to the contour of the treatment area. Synonyms include Conformal External Beam Radiation Therapy (CEBRT), 3-D radiation therapy (3-DRT), 3-D Conformal Beam Radiation Therapy (3-DCBRT), 3-D Conformal Radiation Therapy (3-DCRT), and 3-D External Beam Radiation Therapy (3-DEBRT, 3-DXBRT).

Conventional External Beam Radiotherapy (2DXRT) is delivered via 2-D beams using a linear accelerator. Conventional refers to the way the treatment is planned on a simulator to target the tumor. It consists of a single beam of radiation delivered to the patient from several directions. It is reliable, but is being surpassed by Conformal and other more advanced modalities due to the reduced irradiation of healthy tissue.

Because of the increased complexity of treatment planning and delivery techniques, Electronic Portal Imaging Devices (EPIDs) have been developed. The most common EPIDs are video-based systems; on-line digital port images are captured and analyzed before or during treatment. These systems are used for pre-treatment verification of IMRT fields and to reduce errors in patient positioning.

Fractionation: A small fraction of the entire prescribed dose of radiation is given in each treatment or session. Individual treatment plans are created to minimize the side effects for normal tissue. The typical fractionation schedule for adults is once per day, five days a week. Hyperfractionation (Superfractionation) refers to radiation given in smaller doses twice a day. In Hypofractionation, individual doses are given less often than daily, such as in two-five sessions.

Image-Guided Radiation Therapy (IGRT) combines IMRT with On-Board Imaging (OBI) scans. It visualizes the patient's anatomy during treatments and allows for real-time adjustment of the beams. Since tumors move between treatments and during treatments due to breathing, IGRT ensures correct patient positioning and reduces healthy tissue damage.

IMRT (Intensity Modulated Radiation Therapy) creates a 3-D radiation dose map to treat the tumor. It uses a multi-leaf collimator to modulate or control the outlines and intensity of the radiation field during cancer treatment. Due to its precision it can spare more healthy tissue, but it also requires detailed data collection and takes longer than conventional therapy.

Stereotactic Radiosurgery (SRS) is a single-session procedure used to treat brain tumors and other brain disorders that cannot be treated by regular surgery. The patient's head is placed in a special frame, which is attached to the patient' skull. The frame is used to aim high-dose radiation beams directly at the tumor inside the patient's head. The radiation dose given in one session is usually less than the total dose that would be given with radiation therapy. However, the tumor receives a very high one-time dose of radiation with radiosurgery versus smaller fractions over time with radiation therapy. It is also known as Stereotaxic Radiosurgery or Radiation Surgery.

Stereotactic Radiation Therapy (SRT) is an approach similar to Stereotactic Radiosurgery which delivers radiation to the target tissue. However, the total dose of radiation is divided into several smaller doses given over several days, rather than a single large dose. The treatment time per session typically ranges from 30 to 90 minutes for two-five sessions. It can be used to treat both brain and extracranial tumors.

2. Types of Radiation Equipment:

A. Particle Beam (Proton):

Particle beams use heavy charged subatomic particles to deliver radiation to the tumor. Unlike the other equipment forms, some particle beams can only penetrate a short distance into tissue. Therefore, they are often used to treat cancers located on the surface of or just below the skin. There are only a few facilities that operate particle beam (or cyclotron) units, which can be used to treat brain cancers and fractionated to treat other cancers. There are currently only 5 facilities in the United States and the cost of more than $100 million will limit their expansion.

B. Linear Accelerator (X-Ray):

The linear accelerator produces high energy x-rays that are collected to form a beam that matches the size and shape of the patient's tumor. The patient lies on a movable couch and radiation is transmitted through the gantry, which rotates around the patient. Radiation can be delivered to the tumor from any angle by rotating the gantry, moving the couch, or moving the accelerator with a robotic arm. The accelerator must be located in a room with lead and concrete walls to keep the rays from escaping. A conventional linac requires modifications, such as additional equipment, in order to be used for IMRT or other advanced techniques.

Minimal equipment requirements for a linear accelerator include:

1. at least 1 teletherapy unit, with an energy exceeding 1 megavolt (MV); the distance from the source to the isocenter must be at least 80 cm;

2. access to an electron beam source or a low energy X-ray unit;

3. adequate equipment to calibrate and measure dosimetric characteristics of all treatment units in the department;

4. capability to provide appropriate dose distribution information for external beam treatment and brachytherapy;

5. equipment for accurate simulation of the treatment units in the department (in general, one simulator can service 2-3 megavoltage treatment units);

6. field-shaping capability; and

7. access to CT scanning capability.

The annual capacities for linear accelerator equipment can greatly fluctuate, due to the varying capabilities of the models of equipment and the physician practice patterns. A conventional linear accelerator using previously generated images will have a greater capacity than a machine with

IMRT or IGRT capabilities (Novalis TX, Tomotherapy, Trilogy, Synergy, X-Knife, etc.) because of the shorter set-up and treatment times per case. Like pieces of equipment can have different capacities depending on the extent of fractionation and image guidance use. In addition, the average treatment time for highly specialized techniques such as total body irradiation, or for treating children is longer. There is also linac equipment designed strictly to provide Stereotactic Radiotherapy in one-five treatment sessions (e.g. Cyberknife). These specialized linacs have an even lower capacity because of the treatment time associated with this type of care.

C. Cobalt-60 (Photon):

This modality, best known by the trade name of Gamma Knife, is used to perform Stereotactic Radiosurgery. It is primarily used to treat brain tumors, although it can also be used for other neurological conditions like Parkinson's Disease and Epilepsy. Its use is generally reserved for cancers that are difficult or dangerous to treat with surgery. The radiation damages the genetic code of the tumor in a single treatment, preventing it from replicating and causing it to slowly shrink. Installation of a Gamma Knife system costs between $3.4 and $5 million, plus an additional $0.25 to $0.5 million every 5-10 years to replenish the cobalt-60 power source.

The Gamma Knife consists of a large shield surrounding a large helmet-shaped device with 201 separate, fixed ports that allow the radiation to enter the patient's head in small beams that converge on the designated target. A rigid frame is attached to the patient's skull to provide a solid reference for both targeting and treatment. The patient is then sent for imaging, to accurately determine the position of the target. The computer system develops a treatment plan to position the patient and the paths and doses of radiation. The patient is positioned with the head affixed to the couch, and the treatment is delivered. The patient goes home the same day.

3. Status of South Carolina Providers:

A. Linear Accelerators:

There are currently 28 facilities either operating or approved for a total of 55 linear accelerators in South Carolina. In 2008, the 46 operational linear accelerators averaged 5,684 treatments per unit. The utilization for each provider per linear accelerator was:

Provider	# Accelerators	Treatments/ Accelerator
Cancer Ctr. Carolinas Eastside	1	10,553
Radiological Associates of Aiken	1	7,371
Carolina Regional Radiation	2	7,168
Rock Hill Radiation	2	7,105
RMC-Orangeburg/Calhoun	1	7,060
SC Oncology Associates	2	6,720

Cancer Ctr. Carolinas Oconee		1	6,550
AnMed Health Med. Ctr.		2	6,391
Beaufort-Hilton Head Radiation		1	6,369
Greenville Memorial Hospital		3	6,103
Georgetown Memorial		1	5,903
Palmetto Health Richland		2	5,855
Spartanburg Regional		3	5,827
Cancer Center Carolinas		1	5,821
Trident Regional		2	5,731
Beaufort Memorial Hospital	*1*	1	5,143
Lexington Medical Ctr.		2	4,800
McLeod Regional		4	4,791
Tuomey Regional		2	4,704
Carolinas Hospital System		1	4,557
Roper Hospital		3	4,468
MUSC		4	4,202
Self Memorial		2	3,295

1 2007 Data.

B. Gamma Knife:

Palmetto Health Richland performed 206 Gamma Knife treatments in 2008. MUSC's Gamma Knife became operational in February 2010.

4. Certificate of Need Standards for Radiotherapy

1. Because of the great disparity in equipment capabilities and utilization practices between providers, no capacity standards are established for radiotherapy equipment.

2. The service area for a Stereotactic Radiosurgery unit is defined as all providers within 45 minutes one-way automobile travel time.

3. Hospitals proposing to establish a linac should offer comprehensive oncology and support services.

4. Applicants for a linac not operated by a hospital must document referral agreements from health care providers that would justify the establishment of such services.

5. The applicant must document the need for the expansion of or the addition of a linac, based on the most current utilization data available. The existing resources must be considered and documentation presented as to why the existing resources are not adequate to meet the needs of the service area.

6. The applicant shall document referral sources for patients within its service area, including letters of support from physicians and health care facilities indicating a willingness to refer patients to the proposed service, with expected annual referral volumes. For a new facility, the applicant must document where the potential patients for the facility will come from and the expected shift in patient volume from existing providers. For the expansion of an existing facility, the applicant must provide patient origin information on the current facility.

7. The applicant must affirm the following:

   A. All treatments provided will be under the control of a board certified or board eligible radiation oncologist;

   B. The applicant will have access to a radiation physicist certified or eligible for certification by the American Board of Radiology or its equivalent;

   C. The applicant will have access to simulation equipment capable of precisely producing the geometric relationships of the equipment to be used for treatment of the patient;

   D. The applicant will have access to a custom block design and cutting system;

   E. The applicant will have access to a computerized treatment planning system;

   F. The applicant will have access to diagnostic imaging technology (X-Ray, CT, ultrasound); and

   G. The institution shall operate its own tumor registry or actively participate in a central tumor registry.

8. Due to the unique nature and limited need for this type of equipment, the applicant should document how it intends to provide accessibility for graduate medical education students in such fields as neurosurgery and oncology.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating Certificate of Need applications for these services:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Projected Revenues;
e. Projected Expenses;

f. Financial Feasibility; and
g. Cost Containment.

The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

5. Certificate of Need Standards for Stereotactic Radiosurgery

1. The capacity of a dedicated Stereotactic Radiosurgery unit is 300 procedures annually. This is based on an average of two procedures per day times three days per week times 50 weeks per year.

2. The service area for a dedicated Stereotactic Radiosurgery unit is defined as all facilities within 90 minutes one-way automobile travel time.

3. New Radiosurgery services shall only be approved if the following conditions are met:

   A. All existing units in the service area have performed at a combined use rate of 80 percent of capacity for the most recent year; and

   B. An applicant must project that the proposed service will perform a minimum of 200 procedures annually within three years of initiation of service, without reducing the utilization of existing units below the 80 percent threshold.

4. Expansion of an existing radiosurgery service shall only be approved if the service has operated at a minimum use rate of 80 percent of capacity for each of the past two years and can project a minimum of 200 procedures per year on the additional equipment within three years of its implementation.

5. The applicant shall project the utilization of the service, to include:

   A. Epidemiological evidence of the incidence and prevalence of conditions for which radiosurgery treatment is appropriate, to include the number of potential patients for these procedures;

   B. The number of patients of the applicant who were referred to other radiosurgery providers in the preceding three years and the number of those patients who could have been served by the proposed service; and

   C. Current and projected patient origin information and referral patterns for the facility's existing radiation therapy services. The applicant shall document the number of additional patients, if any, that will be generated through changes in referral patterns, recruitment of specific physicians or other changes in circumstances.

6. The applicant must include letters of support from physicians and health care facilities indicating a willingness to refer patients to the proposed service.

7. The applicant must document that protocols will be established to assure that all clinical radiosurgery procedures performed are medically necessary and that alternative treatment modalities have been considered.

8. The applicant must affirm the following:

   A. The radiosurgery unit will have a board certified neurosurgeon and a board certified radiation oncologist, both of whom are trained in stereotactic radiosurgery;

   B. The applicant will have access to a radiation physicist certified or eligible for certification by the American Board of Radiology or its equivalent;

   C. Dosimetry and calibration equipment and a computer with the appropriate software for performing radiosurgical procedures will be available;

   D. The applicant has access to a full range of diagnostic technology, including CT, MRI and angiography; and

   E. The institution shall operate its own tumor registry or actively participate in a central tumor registry.

9. Due to the unique nature and limited need for this type of equipment, the applicant should document how it intends to provide accessibility for graduate medical education students in such fields as neurosurgery and oncology.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating certificate of need applications for these services:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Projected Revenues;
e. Projected Expenses;
f. Financial Feasibility; and
g. Cost Containment.

The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

MEGAVOLTAGE VISITS

REGION & FACILITY	# UNITS	FY2006	FY2007	FY2008
I				
ANDERSON COUNTY				
ANMED HEALTH MEDICAL CENTER	2	12,199	10,811	12,781
CHEROKEE COUNTY				
GIBBS REGIONAL CANCER CTR SATELLITE *1*	(1)	---	---	---
GREENVILLE COUNTY				
CANCER CENTERS OF THE CAROLINAS	1	5,455	6,175	5,821
CANCER CENTERS CAROLINAS - EASTSIDE	1	9,700	11,563	10,553
GREENVILLE MEMORIAL MEDICAL CENTER	3	16,707	17,669	18,309
GREER MEDICAL CAMPUS CANCER CTR *2*	1	---	---	---
OCONEE COUNTY				
CANCER CENTERS CAROLINAS - OCONEE CO.	1	5,799	6,303	6,550
SPARTANBURG COUNTY				
CANCER CENTER CAROLINAS - MARY BLACK *3*	1	---	---	---
SPARTANBURG REGIONAL MED CTR	3	17,953	18,853	17,480
VILLAGE AT PELHAM CANCER CENTER *1*	1	---	---	---
II				
GREENWOOD COUNTY				
SELF REGIONAL HEALTHCARE	2	6,694	6,060	6,589
LANCASTER COUNTY				
LANCASTER RADIATION THERAPY CTR *4*	1			---
LEXINGTON COUNTY				
LEXINGTON MEDICAL CENTER	2	12,956	12,215	9,599
NEWBERRY COUNTY				
NEWBERRY ONCOLOGY ASSOCIATES *5*	1	---	---	---
RICHLAND COUNTY				
PALMETTO HEALTH RICHLAND				
LINEAR ACCELERATORS	2	10,895	12,065	11,710
GAMMA KNIFE	1	240	232	206
SOUTH CAROLINA ONCOLOGY ASSOCIATES	4	17,420	20,242	26,881
YORK COUNTY				
ROCK HILL RADIATION THERAPY CENTER	2	11,800	14,721	14,210

MEGAVOLTAGE VISITS

REGION & FACILITY		# UNITS	FY2006	FY2007	FY2008
III					
FLORENCE COUNTY					
CAROLINAS HOSPITAL SYSTEM		1	4,953	5,358	4,557
MCLEOD REGIONAL MEDICAL CENTER		4	16,562	17,842	19,164
GEORGETOWN COUNTY					
GEORGETOWN MEMORIAL HOSPITAL		1	5,416	5,466	5,903
HORRY COUNTY					
CAROLINA REGIONAL RADIATION CENTER	*6*	3	14,032	13,107	14,335
SUMTER COUNTY					
TUOMEY		2	10,041	9,892	9,407
IV					
AIKEN COUNTY					
RADIATION ONCOLOGY CTR OF AIKEN	7	2	6,134	6,916	7,371
BEAUFORT COUNTY					
BEAUFORT/HILTON HEAD RAD ONCOLOGY CTR		1	5,412	5,745	6,369
BEAUFORT MEMORIAL HOSPITAL	*8*	1	2,053	5,143	5,143
CHARLESTON COUNTY					
MUSC MEDICAL CENTER	*9*				
LINEAR ACCELERATORS		5	15,116	16,810	16,806
GAMMA KNIFE		1			
ROPER HOSPITAL	*10*	4	12,368	12,877	13,403
TRIDENT MEDICAL CENTER	*11*	2	10,794	11,971	11,461
ORANGEBURG COUNTY					
REGIONAL MED CTR ORANGEBURG/CALHOUN		1	5,722	5,545	7,060
TOTAL		55	236,181	253,349	261,462

1 GIBBES LINAC APPROVED 3/31/03; APPEALED. CON TO MOVE PROPOSED GIBBES LINAC TO VILLAGE AT PELHAM APPEALED 2/12/08. CONS ISSUED FOR GIBBES BY SUPREME CT RULING.
2 CON ISSUED 10/12/07, SC-07-53.
3 CON ISSUED BY SUPREME COURT RULING 3/31/10.
4 CON APPROVED 2/15/08; APPEALED. APPEAL DISMISSED 8/5/09; SC-09-39 ISSUED 8/12/09.
5 CON APPROVED 3/20/06.
6 CON APPROVED FOR A TOMOTHERAPY UNIT AS A 3RD LINAC; APPEALED. CON ISSUED 7/18/07.
7 CON ISSUED TO TRANSFER OWNERSHIP FROM AIKEN REGIONAL & ADD 2ND LINAC 6/11/09, SC-09-29.
8 DATA NOT AVAILABLE FOR 2008
9 CON FOR GAMMA KNIFE ISSUED 6/8/09. CON FOR 5TH LINAC-ISSUED 7/8/09.
10 CON ISSUED FOR A CYBERKNIFE LINEAR ACCELERATOR 8/10/06. CON APPROVED FOR 3RD CONVENTIONAL LINAC 8/5/09.
11 CON ISSUED FOR REPLACEMENT LINAC 2/26/09 SC-09-07.

CHAPTER X

POSITRON EMISSION TOMOGRAPHY (PET) AND PET/CT

Positron Emission Tomography (PET) uses small concentrations of radioactive material injected into the blood to capture color images of cellular metabolism. It allows the study of metabolic processes such as oxygen consumption and utilization of glucose and fatty acids. Cancer cells utilize more glucose than normal cells, so PET can be used to reveal the presence or track the spread of cancer. It is quantitative and very sensitive, so only small amounts of isotopes are needed. The isotopes only have about a two hour half-life and are quickly expelled from the body.

PET was developed in the 1970s and was primarily used for research focusing on cerebral function and detection and assessment of coronary artery disease. Recent research has centered on the diagnosis and staging of cancer and neurological applications such as epilepsy, Alzheimer's and Parkinson's diseases. PET is covered for Medicare patients with lung, breast, colorectal, head and neck and esophageal cancers; melanomas; certain thyroid diseases; neurology; and heart disease uses.

The process takes approximately 45 minutes to an hour to perform. A Computerized Tomography (CT) scanner produces cross-sectional images of anatomical details of the body. These images are taken separately, and then fused with the PET images for interpretation. The process requires a nuclear medical technologist certified for both PET and CT or dually certified in radiography.

Several manufacturers have now developed combined PET/CT scanners that can acquire both image sets simultaneously, giving radiologists a more complete picture in about half the time. A PET/CT scanner costs between $2,000,000-$2,7000,000 dollars. Installing and operating a PET scanner typically costs around $1,600,000 in capital costs plus annual staffing and operational costs of $800,000. Charges vary from around $2,500 - $4,000 depending on the type and location of the scan.

Due to the on-going development of this technology, it is anticipated that PET and PET/CT will become a standard diagnostic modality in the fields of cardiology, oncology and neurology. Due to the current cost of this technology and the uses approved for reimbursement, it is more appropriate that this technology be available for health care facilities providing specialized therapeutic services such as open heart surgery and radiation oncology. Note: in the Certificate of Need standards cited below, the terms PET and PET/CT are interchanged. The Department does not differentiate between these modalities in defining these standards. The addition of a CT component to an existing PET service is not considered to be a new service that would trigger CON review and is interpreted by the Department to be the replacement of like equipment with similar capabilities.

Certificate of Need Standards

1. Hospitals that provide specialized therapeutic services (open heart surgery and/or radiation therapy) should have either fixed or mobile PET services for the diagnosis of both inpatients and outpatients. Other hospitals must document that they provide a sufficient range of

comprehensive medical services that would justify the need for PET services. Applicants for a freestanding PET service not operated by a hospital must document referral agreements from health care providers that would justify the establishment of such services.

2. Full-time PET scanner service is defined as having PET scanner services available five days per week. Fixed PET scanners are considered to be in operation five days per week. Capacity is considered to be 1,500 procedures annually. For PET/CT equipment, only procedures that utilize the PET component should be counted; procedures using the CT component as a stand-alone scanner are not included. Capacity for shared mobile services will be calculated based on the number of days of operation per week at each participating facility.

3. Applicants proposing new fixed PET services must project at a minimum 750 PET clinical procedures per year (three clinical procedures/day x 250 working days) by the end of the third full year of service. The projection of need must include proposed utilization by both patient category and number of patients to be examined, and must consider demographic patterns, patient origin, market share information, and physician/patient referrals. An existing PET service provider must be performing at 1,250 clinical procedures (five clinical procedures x 250 days) per PET unit annually prior to the approval of an additional PET machine.

4. In order to promote cost-effectiveness, the use of shared mobile PET units should be considered. Applicants for a shared mobile scanner must project an annual minimum of three clinical procedures/day times the number of days/week the scanner is operational at the facility by the end of the third full year of service.

5. The applicant must demonstrate through cooperative and sharing agreements and letters of support how it will accommodate physicians, other health care institutions and patients from its own region and beyond.

6. The applicant agrees in writing to provide to the Department utilization data on the operation of the PET service.

7. The Department encourages all applicants and providers to share their outcome data with appropriate registries and research studies designed to improve the quality of patient care.

8. A provider seeking Medicare reimbursement must be accredited after January 1, 2012.

Quality

CMS recently announced that PET/CT providers will have to be accredited by January 1, 2012 in order to ensure the quality of the pictures produced and the safety of the Medicare beneficiaries undergoing these procedures. TJC, the American College of Radiology and the Intersocietal Accreditation Commission have been designated as accrediting organizations by CMS.

The operational or approved PET scanners in the state are listed on the following pages.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating certificate of need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Acceptability;
e. Financial Feasibility;
f. Ability of the Applicant to Complete the Project; and
g. Cost Containment.

The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

POSITRON EMISSION TOMOGRAPHY (PET) AND PET-CT UTILIZATION

REGION/COUNTY	FACILITY	SCANNERS	FY06 SCANS	FY07 SCANS	FY08 SCANS	CON/DATE
I						
ANDERSON	ANMED HEALTH CANCER CENTER	MOBILE 2 DAYS	372	423	509	
GREENVILLE	THE CAROLINAS CLINICAL PET INSTITUTE	FIXED	2,203	1,958	2,330	
GREENVILLE	GREENVILLE MEMORIAL HOSPITAL	MOBILE 4 DAYS	49	713	661	CON 5/1/06
SPARTANBURG	SPARTANBURG REGIONAL MEDICAL CTR	FIXED	880	1,234	1,589	REPLACE MOBILE W/ FIXED 8/22/06
II						
GREENWOOD	SELF REGIONAL HEALTHCARE	MOBILE 3 DAYS	---	415	545	CONVERT TO 3 DAYS/WK & CONV TO PET/CT 11/27/06
LEXINGTON	LEXINGTON MED CTR - LEXINGTON	MOBILE 3 DAYS	488	340	444	REPLACE PET W/ PET-CT 3/22/06
RICHLAND	PALMETTO HEALTH BAPTIST	FIXED	1,099	904	954	
RICHLAND	SOUTH CAROLINA HEART CENTER	FIXED	---	---	---	CON 3/17/08
RICHLAND	SOUTH CAROLINA ONCOLOGY ASSOC	FIXED	1,324	1,709	2,213	
YORK	PIEDMONT MEDICAL CENTER	MOBILE 2 DAYS	531	884	1,085	
III						
FLORENCE	CAROLINAS HOSPITAL SYSTEM	MOBILE 1 DAY	232	234	248	
FLORENCE	MCLEOD REGIONAL MEDICAL CENTER	FIXED	576	596	672	
GEORGETOWN	GEORGETOWN MEMORIAL HOSPITAL	MOBILE 1 DAY PER 2 WEEKS	146	227	237	CON 10/10/08 TO SHARE 1 DAY/2 WKS

GEORGETOWN	WACCAMAW COMMUNITY HOSPITAL	MOBILE 1 DAY PER 2 WEEKS	---	---	7	CON 10/10/08 TO SHARE 1 DAY/2 WKS
HORRY	COASTAL CANCER CENTER	FIXED	---	---	650	CON 11/15/07
HORRY	GRAND STRAND REGIONAL MEDICAL CTR	MOBILE 2 DAYS	838	951	776	
HORRY	CONWAY HOSPITAL	MOBILE 2 DAYS	80	123	199	
SUMTER	TUOMEY	MOBILE 1/2 DAY	131	160	191	
IV						
AIKEN	AIKEN REGIONAL MEDICAL CENTER	MOBILE 1 DAY	328	426	341	
BEAUFORT	BEAUFORT IMAGING CENTER	MOBILE 2 DAYS	222	224	226	
BEAUFORT	SOUTH CAROLINA CANCER SPECIALISTS	FIXED	299			CONVERTED TO FIXED 7/25/07
CHARLESTON	MUSC MEDICAL CENTER	FIXED	329	1,186	1,559	CON 2/10/06
CHARLESTON	ROPER HOSPITAL	FIXED	823	1,017	1,390	
CHARLESTON	CHARLESTON RADIOLOGISTS	MOBILE 1 DAY	350	431	467	
(CHARLESTON)	(NORTH CHARLESTON DIAGNOSTIC)	(FIXED)	---	---	---	CON 3/20/06, VOIDED
CHARLESTON	TRIDENT HOSPITAL	FIXED	---	---	---	CON 2/26/09
JASPER	SOUTH CAROLINA CANCER SPECIALISTS	FIXED	---	---	---	EXEMPTION 7/24/07
ORANGEBURG	REGIONAL MEDICAL CENTER OF ORANGEBURG & CALHOUN COUNTIES	MOBILE 2 DAYS	62	50	66	CONVERTED TO PET/CT 6/17/09
		TOTALS	**11,362**	**14,205**	**17,359**	

CHAPTER XI

OUTPATIENT FACILITIES

Outpatient facility means a facility providing community service for the diagnosis and treatment of ambulatory patients: (1) that is operated in connection with a hospital; or (2) in which patient care is under the professional supervision of a licensed physician; or (3) that offers to patients not requiring hospitalization the services of licensed physicians and makes available a range of diagnostic and treatment services. Hospital-based outpatient departments vary in scope, but generally include diagnostic laboratory, radiology, and clinical referral services.

A. Ambulatory Surgical Facility

Ambulatory surgery, often described as outpatient or same-day surgery, may be provided in either a hospital or a freestanding Ambulatory Surgical Facility (ASF). An ASF is a distinct, freestanding, self-contained entity that is organized, administered, equipped and operated exclusively for the purpose of performing surgical procedures or related care, treatment, procedures, and/or services, for which patients are scheduled to arrive, receive surgery, or related care, treatment, procedures, and/or services, and be discharged on the same day. The owner or operator makes the facility available to other providers who comprise an organized professional staff, i.e. an open medical staff. This definition does not apply to any facility used as an office or clinic for the private practice of licensed health care professionals.

For purposes of this Plan, an endoscope is defined as a flexible, semi-flexible or rigid instrument, which may or may not have a light attached, that is inserted into a natural orifice in a non-sterile, clean environment, to visually inspect for purposes of screening and diagnosis and to perform therapeutic treatment of the interior of a bodily canal or a hollow organ (such as the colon, bladder, stomach or nasal sinuses).

An Endoscopy ASF is defined as one organized, equipped, and operated exclusively for the purpose of performing surgical procedures or related treatments through the use of an endoscope. Any appropriately licensed and credentialed medical specialist can perform endoscopy only surgical procedures or related treatments at an Endoscopy ASF.

A substantial increase has occurred in both the number and percentage of ambulatory surgeries performed and in the number of approved ASFs. This trend has generally been encouraged because many surgical procedures can be safely performed on an outpatient basis at a lower cost. However, hospitals have expressed concern that ASFs that are not hospital joint ventures are impacting their ability to fund their services. CMS has revised the payment system for ASFs, setting a new compensation rate of 65% of the hospital outpatient rate under Medicare, to be phased in by 2011. This new rate is anticipated to particularly impact endoscopy centers, which are currently paid 89% of the hospital rate, while other specialties may receive increased reimbursement. At the same time, CMS added more than 700 procedures to the list for which ASFs can be reimbursed.

In 2008, a total of 344,612 outpatient surgeries and 258,974 endoscopies were performed in either a freestanding surgical center or a hospital in South Carolina, accounting for 69.0% of all surgeries and 85.1% of all endoscopies.

Certificate of Need Standards

1. The county in which the proposed facility is to be located is considered to be the service area for inventory purposes. The applicant may define a proposed service area that encompasses additional counties, but the largest percentage of the patients to be served must originate from the county in which the facility is to be constructed.

2. The applicant must identify the physicians who are affiliated or have an ownership interest in the proposed facility by medical specialty. These physicians must identify where they currently perform their surgeries and whether they anticipate making any changes in staff privileges or coverage should the application be approved.

3. For a new facility, the applicant must document where the potential patients for the facility will come from and where they are currently being served, to include the expected shift in patient volume from existing providers. For the expansion of an existing facility, the applicant must provide patient origin information on the current facility.

4. The applicant must document the need for the expansion of or the addition of an ASF, based on the most current utilization data available. This need documentation must include the projected number of surgeries or endoscopic procedures to be performed by medical specialty. The existing resources must be considered and documentation presented as to why the existing resources are not adequate to meet the needs of the community.

5. An application for a new ASF must contain letters of support from physicians in the proposed service area other than those affiliated with the proposed facility. These letters should indicate the physicians' intent to utilize the facility and/or refer patients to the facility. Doctors should state the number of surgeries they anticipate performing or the number of patients they anticipate referring to the facility per year. If the physicians do not intend to utilize or refer patients to the facility, they should state why they believe the existing resources are not adequate to meet the needs of the community and why a need exists for the project.

6. The applicant must document the potential impact that the proposed new ASF or expansion of an existing ASF will have upon the existing service providers and referral patterns.

7. All new Certificate of Need approvals by the Department will not restrict the specialties of ASFs. However, the Department believes that Ambulatory Surgery Facilities open to and equipped for all surgical specialties will better serve the community than those targeted

towards a single specialty or group of practitioners. For an ASF approved to perform only endoscopic procedures, another CON would be required before the center could provide other surgical specialties.

8. All proposed Ambulatory Surgical Facilities, other than those restricted to endoscopic procedures only, must have a minimum of two operating rooms.

9. Before an application for a new general Ambulatory Surgery Facility can be accepted for filing, all existing ASF's in the county where the proposed facility is to be located must have been licensed and operational for an entire year, and must have submitted data on the Department's annual questionnaire to allow for a determination of their utilization. The data will not be prorated or projected into the future but based on actual utilization.

10. Endoscopy suites are considered separately from other operating rooms. Therefore, endoscopy-only ASF's do not impact other ASF's and are not considered competing applicants for CON review purposes. Before an application for a new endoscopy-only ASF can be accepted for filing in a county having a current population of less than 100,000 people, all ASFs with endoscopy suites in the county must have been licensed by the Department and operational for an entire year and must have submitted data on the Department's annual questionnaire to allow for a determination of their utilization. The requirements that all ASFs with endoscopy suites must have been licensed and operational for an entire year and submitted utilization data to the Department will not be applied to applicants for a new endoscopy-only ASF filing in a county having a current population of greater than 100,000 people.

11. The approval of a new general or endoscopy-only ASF in a county does not preclude an existing facility from applying to expand its number of operating rooms and/or endoscopy suites.

12. The applicant for a new ambulatory surgery facility must provide a written commitment that the facility will accept Medicare and Medicaid patients, and that un-reimbursed services for indigent and charity patients will be provided at a percentage that is comparable to all other existing ambulatory surgery facilities, if any, in the service area.

Facilities providing ambulatory surgery services must conform to local, state, and federal regulatory requirements and must commit to seek accreditation from a nationally recognized organization, such as The Joint Commission (TJC), the Accreditation Association for Ambulatory Health Care (AAAHC), or the American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF). Ambulatory surgical services are generally available within 30 minutes one-way automobile travel time of most South Carolina residents. Most ASFs operate five days a week, with elective surgery being scheduled several days in advance.

Quality

The ASC Quality Collaboration (ASCQC) is a voluntary cooperative effort between a number of organizations and companies working to ensure that quality data are measured and reported in a meaningful way. Participants in the National Quality Forum (NQF) include CMS, TJC, AAAJC, American College of Surgeons (ACOS), American Osteopathic Association (AOA), Association of periOPerative Registered Nurses (AORN), and Hospital Corporation of American (HCA).

The NQF has identified six standardized measurements that are feasible and useable as quality indicators. These are:

1. Patient burn;
2. Prophylactic IV antibiotic timing;
3. Patient falls within facility;
4. Wrong site, side, patient, procedure, or implant;
5. Hospital transfer/admission; and
6. Appropriate surgical site hair removal.

These quality indicators are proposed as goals for performance improvement measurement and improvement. CMS is developing a quality measure reporting system for ASFs, but the guidelines have not been released yet. Facilities will eventually face a two percent financial penalty for failing to report data, but, for now, any data collection efforts are voluntary.

If and when a data reporting system is created under CMS, the results for ASFs should be used in evaluating CON applications.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating Certificate of Need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Adverse Effects on Other Facilities
c. Community Need Documentation;
d. Distribution (Accessibility);
e. Financial Feasibility;
f. Cost Containment;
g. Projected Revenues;
h. Projected Expenses;
i. Ability of the Applicant to Complete the Project; and
j. Staff Resources.

The number of surgeries performed on an outpatient basis and the number of ASFs approved and licensed have increased over time. However, there is concern that ASFs are being proposed as a method of increasing reimbursement for procedures currently being performed in physicians' offices through the "facility fee" built into the reimbursement mechanisms, to the detriment of a hospital's ability to provide the range of services needed. The benefits of improved accessibility will be weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

The following facilities have been approved or are licensed as ambulatory surgical facilities (utilization data, if applicable, are from 2008):

2008 ASF Utilization

Name of Facility:	County	# of ORs	# of Endos	Total # of Suites	Total Operations	Total Endos	Combined Total	Operations per OR	Endos per Suite	Footnote
Region I:										
AnMed Health Medicus Surgery Center	Anderson	3		3	3,976	514	4,490	1,325		
Bearwood Ambulatory Surgery Center	Anderson	1		1	256		256	256		
Physician Surgery Center at AnMed Health	Anderson	3		3	655		655	328		*1*
Upstate Endoscopy Center	Anderson		2	2		3,822	3,822			
Center for Special Surgery, The	Greenville	2		2	1,430		1,430	715		
Cross Creek Surgery Center	Greenville	4		4	2,773		2,773	693		
Endoscopy Center of the Upstate	Greenville		3	3		5,018	5,018		1,673	
Greenville Endoscopy Center	Greenville		3	3		5,379	5,379		1,793	
Greenville Endoscopy Center - Patewood	Greenville		3	3		5,449	5,449		1,816	
GHS Outpatent Surgery Center – Patewood	Greenville	6	4	10	5,453	2,540	7,993	909	635	*2*
Greenville Surgery Center	Greenville	4		4			0	0		*3*
Jervey Eye Center	Greenville	3		3	3,523		3,523	1,174		
Upstate Surgery Center	Greenville	2		2	3,401		3,401	1,701		
Blue Ridge Surgery Center	Oconee	2		2	3,014		3,014	1,507		
Upstate Pain Management & Surgery Center	Oconee	2		2	878		878	439		
Ambulatory Surgery Ctr - Spartanburg	Spartanburg	7	2	9	7,273	3,931	11,204	1,039	1,966	*4*
Spartanburg Urology Surgicenter	Spartanburg	2		2	4,035		4,035	2,018		*5*
Surgery Center at Pelham	Spartanburg	4	2	6	3,671	1,211	4,882	918	606	
Westside Eye Center	Spartanburg	2		2	855		855	428		
Region II:										
Greenwood Endoscopy Center	Greenwood		4	4		8,788	8,788		2,197	

Name of Facility:	County	# of ORs	# of Endos	Total # of Suites	Total Operations	Total Endos	Combined Total	Operations per OR	Endos per Suite	Footnote
Surgery Ctr. at Self Memorial Hospital	Greenwood	5		5	4,715		4,715	943		
Surgery Center at Edgewater	Lancaster	3	2	5	1,089	0	1,089	363	0	*6*
Surgery & Laser Center at Professional Park	Laurens	2		2	3,068		3,068	1,534		
Columbia Surgery Center	Lexington	2		2	242		242	121		
Midlands Endoscopy Center	Lexington		2	2		2,140			1,070	
Moore Orthopaedic Clinic Outpatient Surgery	Lexington	2		2	1,441		1,441	0		
Outpt Surgery Center Lexington Med Ctr - Irmo	Lexington	4		4	1,662		1,662	416		
Outpt Surgery Center Lexington Med Ctr - Lexington	Lexington	4	1	5	2,122	1,792	3,914	531	1,792	
South Carolina Endoscopy Center	Lexington		4	4		11,140	11,140		2,785	
Urology Surgery Center	Lexington	2		2	2,400		2,400	1,200		
Berkeley Endoscopy Center	Richland		2	2		2,318	2,318		1,159	
Columbia Eye Surgery Center	Richland	4		4	4,887		4,887	1,222		
Columbia GI Endoscopy Center	Richland		4	4		5,685	5,685		1,421	
Lake Murray Endoscopy Center	Richland		2	2		1,585	1,585		793	
Midlands Orthopaedics Surgery Center	Richland	3		3	5,366		5,366	1,789		
Palmetto Surgery Center	Richland	4		4	5,390		5,390	1,348		
Parkridge Surgery Center	Richland	4		4	2,902		2,902	726		
(Providence Hospital Surgery Center)	Richland	(4)		(4)	512		512	-128		*7*
South Carolina Endoscopy Center - North East	Richland		5	5		4,119	4,119		824	
South Carolina Med Endoscopy Ctr.	Richland		2	2		3,381	3,381		1,691	*8*
Carolina Surgical Center	York	4		4	4,597		4,597	1,149		
Center for Orthopaedic Surgery	York	3		3	3,598		3,598			
York County Endoscopy Center	York		3	3						*9*

Name of Facility:	County	# of ORs	# of Endos	Total # of Suites	Total Operations	Total Endos	Combined Total	Operations per OR	Endos per Suite	Footnote
Region III:										
Darlington Endoscopy Center	Darlington		2	2		523	523		262	
Florence Surgery & Laser Center	Florence	2		2	2,816		2,816	1,408		
McLeod Ambulatory Surgery Center	Florence	2		2	1,275		1,275	638		
Physicians Surgical Center of Florence	Florence	4	2	6	3,334	2,425	5,759	834	1,213	
Atlantic Surgery Center	Georgetown	1		1	1,002		1,002	1,002		
Bay Microsurgical Unit	Georgetown	1		1	3,225		3,225	3,225		
Waccamaw Endoscopy Center	Georgetown		1			1,642	1,642		1,642	
Carolina Bone and Joint Surgery Ctr.	Horry	2		2	1,832		1,832	916		
Grande Dunes Surgery Center	Horry	3	2	5	2,479	1,338	3,817	826	669	
Ocean Ambulatory Surgery Center	Horry	2		2	1,886		1,886			
Parkway Surgery Center	Horry	2		2	2,523		2,523	1,262		
Rivertown Surgery Center	Horry	2		3	2,379	435	2,814	1,190		
Seacoast Med Ctr Ambulatory Surgery	Horry	3		3	2,180	1,312	3,492	727		
Strand GI Endoscopy Center	Horry		2	2		4,376	4,376		2,188	
Wesmark Ambulatory Surgery Facility	Sumter	2		2	1,738	11	1,749	869		
Region IV:										
Ambulatory Surgical Center of Aiken	Aiken	4	1	5	1,990	1,878	3,868	498	1,878	
Carolina Ambulatory Surgery Center	Aiken	1		1	1,557		1,557			
Bluffton-Okatie Outpatient Center	Beaufort	2	1	3	1,048	858	1,906	524	858	
Laser and Skin Surgery Center	Beaufort	2		2	2,326		2,326	1,163		
Outpatient Surgery Ctr. Hilton Head	Beaufort	3	2	5	3,152	2,253	5,405	1,576	1,127	*10*
Surgery Center of Beaufort	Beaufort	3		3	4,684	1,050	5,734	1,561		

Name of Facility:	County	# of ORs	# of Endos	Total # of Suites	Total Operations	Total Endos	Combined Total	Operations per OR	Endos per Suite	Footnote
Roper Hospital Ambulatory Surgery - Berkeley	Berkeley	3		3	151	620	771	50		
Charleston Endoscopy Center	Charleston		4	4		8,789	8,789		2,197	
Charleston Surgery Center	Charleston	4	1	5	4,012		4,012	1,003	0	
Elms Endoscopy Center	Charleston		3	3		6,074	6,074		2,025	
Palmetto Endoscopy Center	Charleston		2	2		8,167	8,167		4,084	
Physicians' Eye Surgery Center	Charleston	2		2	2,478		2,478	1,239		
Roper Hosp Ambulatory Surg & Pain Mgt - James Island	Charleston	4		4			0	0		*11*
Roper West Ashley Surgery Center	Charleston	5		5	3,624		3,624	725		*11*
Southeastern Spine Institute	Charleston	2		2	2		2	1		*12*
Surgery Center of Charleston	Charleston	1	1	2	2,363	1200	2,363	2,363	1,200	
Trident Eye Surgery Center	Charleston	2		2	2,965		2,965	1,483		
Trident Surgery Center	Charleston	4		4	4,514		4,514	1,129		
West Ashley Endoscopy Center	Charleston		1	1						*13*
Colleton Ambulatory Surgery Center	Colleton	2	1	3	809	660	1,469	405	660	
Lowcountry Outpatient Surgery Ctr.	Dorchester	2		2	2,630		2,630	1,315		
(Edisto Surgery Center)	Orangeburg	(4)	(2)	(6)			0	0		*14*
TOTALS		165	76	241	150,158	112,423	262,581	923	1,407	

Ambulatory Surgical Facility (ASF) Footnotes

--- No data available for facility during reporting period.

1 CON issued 1/29/07 for an ASF with 3 ORs, SC-07-03. Licensed 6/5/08.

2 CON issued to add 2 Endoscopy Suites for a total of 4, 12/10/09, SC-09-54.

3 Formerly HealthSouth Surgery Center.

4 CON issued 10/22/07 to add 2 additional ORs and 1 Endoscopy Suite for a total of 9 ORs and 3 Endoscopy Suites, SC-07-55.

5 CON issued 10/22/07 to add 2 additional ORs for a total of 4 ORs, SC-07-54. Licensed for 4 ORs 1/15/10. Formerly Spartanburg Urology Surgicenter.

6 CON approved 1/23/04, appealed. CON issued 6/10/05 after dismissal of appeal, SC-05-40. CON issued 6/15/07 to add an additional OR for a total of 3 ORs and 2 Endoscopy Suites, SC-07-24; formerly Carolina Surgery Center. Licensed for the 3 ORs on 2/27/08; the 2 Endoscopy Suites were licensed 8/5/09.

7 Facility closed 7/1/08.

8 CON denied to expand from 2 to 4 Endoscopy Suites 9/19/03; under appeal.

9 CON approved 2/26/07 for an ASF with 3 Endoscopy Suites restricted to gastroenterology procedures only; appealed. CON SC-08-18 issued 6/12/08. Licensed 2 of the Endoscopy Suites 6/26/09.

10 CON issued 8/24/09 to add 1 OR for a total of 3 ORs and 2 Endoscopy Suites, SC-09-41. New OR licensed 3/22/10.

11 CON issued 1/3/09 to transfer 2 ORs from Roper West Ashley Surgery Center to Roper St. Francis James Island Surgery Center, for a total of 3 ORs at Roper West Ashley Surgery Center and 4 ORs at Roper St. Francis James Island Surgery Center. License decreased from 5 ORs to 3 at Roper West Ashley effective 6/1/09. Roper St. Francis James Island licensed 9/30/09.

12 CON issued 6/12/08 after appeal, SC-08-17. Licensed 11/17/08.

13 CON approved 12/29/09; appealed.

14 CON approved 5/31/05; appealed. CON issued 9/21/06. CON voided 9/19/08.

B. Emergency Hospital Services:

All hospital emergency departments are sub-categorized into four levels of service from I to IV, with I being the highest level of care. These categories are based on modified TJC standards and adopted by the State EMS Advisory Council. Each facility must comply with the following paragraphs corresponding to their designated level of care. These standards do not constitute Certificate of Need criteria. All segments of the population should have basic emergency services available within 30 minutes one-way travel time.

Level I: offers comprehensive emergency care 24 hours a day, with at least one physician experienced in emergency care on duty in the emergency care area. There is in-hospital physician coverage by members of the medical staff or by senior-level residents for at least medical, surgical, orthopedic, obstetric/gynecologic, pediatric, and anesthesia services. Other specialty consultation is available within approximately 30 minutes; initial consultation through two-way voice communication is acceptable.

Level II: offers emergency care 24 hours a day, with at least one physician experienced in emergency care on duty in the emergency care area, and with specialty consultation available within approximately 30 minutes by members of the medical staff or by senior-level residents. The hospital's scope of services includes in-house capabilities for managing physical and related emotional problems, with provision for patient transfer to another organization when needed.

Level III: offers emergency care 24 hours a day, with at least one physician available to the emergency care area within approximately 30 minutes through a medical staff call roster. Specialty consultation is available by request of the attending medical staff member or by transfer to a designated hospital where definitive care can be provided.

Level IV: offers reasonable care in determining whether an emergency exists, renders lifesaving first aid, and makes appropriate referral to the nearest organization that is capable of providing needed services. The mechanism for providing physician coverage at all times is defined by the medical staff.

According to DHEC Health Licensing, the following facilities are considered to be freestanding emergency services (along with the hospital they are an extension of):

Moncks Corner Medical Center (Trident Medical Center) – Moncks Corner, Dorchester County
Seacoast Medical Center (Loris Community Hospital) – Little River, Horry County
South Strand Ambulatory Care Center (Grand Strand Regional) – Myrtle Beach, Horry County
Roper St. Francis Northwoods (Roper St. Francis) – North Charleston, Charleston County

Certficate of Need Standards for Freestanding Emergency Services

1. A Certificate of Need is required to establish a freestanding emergency service (also referred to as an off-campus emergency service).

2. All off-campus emergency services must be an extension of an existing hospital's emergency service in the same county, unless the applicant is proposing to establish a freestanding emergency service in a county that does not have a licensed hospital. The hospital must have a license that is in good standing and must be in operation to support the off-campus emergency services.

3. Regulation 61-16, Standards for Licensing Hospitals and Institutional General Infirmaries, Section 613, will be used to survey off-campus emergency services, specifically including 24 hour/7 day per week physician coverage on site.

4. An off-campus emergency service must have written agreements with Emergency Medical Services providers and surrounding hospitals regarding serious medical problems, which the off-campus emergency service cannot handle.

5. The physical structure must meet Section 12-6 of the Life Safety Code, New Ambulatory Health Care Centers and must specifically have an approved sprinkler system.

6. The applicant must demonstrate need for this service by documenting where the potential patients for this proposed service will come from and why they are not being adequately served by the existing services in the area.

Relative Importance of Project Review Criteria

The following project review criteria are considered to be the most important in evaluating certificate of need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Community Need Documentation;
c. Distribution (Accessibility);
d. Resource Availability; and
d. Financial Feasibility.

The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

C. Trauma Referral System:

The DHEC Division of Emergency Medical Services has developed and implemented a trauma referral system throughout the state. This system allows any hospital desiring and qualifying as a trauma center to become so designated. The summary definitions below were derived from the American College of Surgeons criteria. The following is a brief description of the criteria for each of the three levels of Trauma Centers. Emergency departments in all trauma centers are required to have adequate staff to include Emergency Department physicians in-house 24 hours per day.

Level I: The highest level of capability available. Generally speaking, this hospital has to have general surgery capability in-house at all times. Anesthesia capabilities are required to be in-house at all times, but this requirement may be met with CRNA's or anesthesiology chief residents. Orthopedic surgery, neurological surgery, and other surgical and medical specialties must be immediately available. Generally, these trauma centers will be attached to medical schools or will have residency programs because of the in-house requirements, since fourth year and senior trauma residents can help meet the requirements of the Level I criteria. The Level I Trauma Center also has the responsibility of providing education and outreach programs to other area hospitals and the public and must also conduct trauma-related research.

Level II: This hospital has extensive capability and meets the needs of most trauma victims. It is required to have general, neurological and orthopedic surgery available when the patient arrives. Anesthesiology capabilities are required to be in-house at all times, but this requirement may be met with CRNA's. Other surgical and medical specialties are required to be on-call and promptly available. These hospitals may develop local procedures for the surgeons being available in the Emergency Department when the patient arrives. The primary difference between Level I and II facilities is that the major surgical specialties are allowed to be on-call in Level II trauma centers but with the clear commitment to be in the Emergency Department when the patient arrives. Level II hospitals do not have the research requirements of a Level I trauma center.

Level III: This hospital is committed to caring for the trauma patient. Level III trauma centers can provide prompt assessment, resuscitation, emergency operations, and stabilization, and also arrange for possible transfer of the patient to a facility that can provide definitive trauma care. These hospitals are required to have general surgery, anesthesia, and radiology on-call and promptly available. The general surgeon is required to be on-call and promptly available in the Emergency Department as the trauma team leader.

CHAPTER XII

LONG TERM CARE FACILITIES AND SERVICES

A. Nursing Facilities:

Nursing facilities provide inpatient care for convalescent or chronic disease residents who require nursing care and related medical services. Such nursing care and medical services are prescribed by, or are performed under the general direction of, persons licensed to practice medicine or surgery in the State. Facilities furnishing primarily domiciliary care are not included. Under www.scdhec.gov the licensing list of nursing facilities also denotes the facilities that have Alzheimer's units. For more specific detail about nursing facilities, refer to Regulation 61-17, Standards for Licensing Nursing Homes.

A ratio of 39 beds/1,000 population age 65 and over is used to project the need for 2012. Since the vast majority of patients utilizing nursing facilities are 65 years of age or older, only this segment of the population is used in the need calculations. A two-year projection is used because nursing facilities can be constructed and become operational in two years.

Certificate of Need Standards

1. Bed need is calculated on a county basis. Additional beds may be approved in counties with a positive bed need up to the need indicated.

2. When a county shows excess beds, additional beds will not be approved, except to allow an individual nursing facility to add some additional beds in order to make more economical nursing units. These additions are envisioned as small increments in order to increase the efficiency of the nursing home. This exception for additional beds will not be approved if it results in three and/or four bed wards. A nursing facility may add up to 16 additional beds per nursing unit to create either 44 or 60 bed nursing units, regardless of the projected bed need for the county. The nursing facility must document how these additional beds will make a more economical unit(s).

Quality

CMS has established the 5-Star Quality Rating System for nursing facilities. It gives consumers the opportunity to see how different nursing facilities have rated on measurements of quality. The system gives each Medicare/Medicaid-participating nursing facility between 1-5 stars with 5 having the highest overall quality and 1 the lowest. This overall score is based on 3 components, each of which is also individually rated. These are:

a. Health inspections – from the past 3 years plus any complaint investigations.
b. Staffing ratios – the number of nursing hours of staff per patient per day, adjusted by the level of need of the patients.
c. Quality measures – 10 physical and clinical measures of patient care, such as incidence of bed sores and changes in mobility.

The system is accessible online and allows the user to compare multiple facilities at the same time. The URL is: http://www.medicare.gov/NHCompare

The Department may use the 5-Star data in evaluating a CON application for additional nursing facility beds at an existing facility.

Relative Importance of Project Review Criteria

The following project review criteria are considered the most important in evaluating Certificate of Need applications for these beds or facilities:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Projected Revenues;
c. Projected Expenses;
d. Net Income;
e. Methods of Financing;
f. Financial Feasibility;
g. Record of the Applicant; and
h. Distribution (Accessibility).

Because nursing facilities are located within approximately thirty (30) minutes travel time for the majority of the residents of the State and at least one nursing facility is located in every county, no justification exists for approving additional nursing facilities or beds that are not indicated as needed in this Plan. The major accessibility problem is caused by the lack of Medicaid funding since the Medicaid Program pays for approximately 65% of all nursing facility residents. This Plan projects the need for nursing facility beds by county. The benefits of improved accessibility do not outweigh the adverse effects caused by the duplication of any existing beds or the placement of Medicaid funds for the beds.

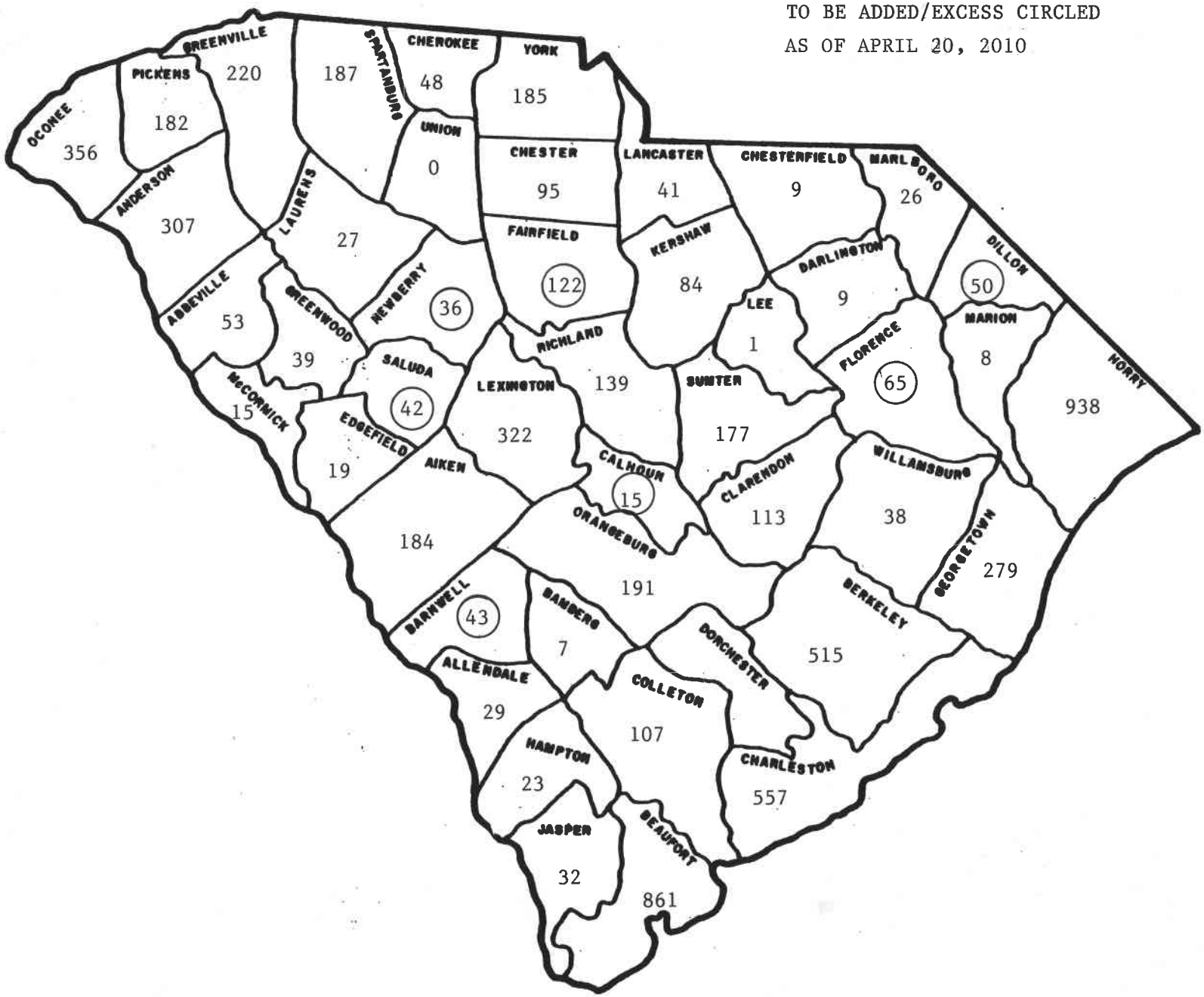
B. Medicaid Nursing Home Permits:

Beginning July 1, 1988, nursing facilities that wish to continue to serve Medicaid residents must apply to the Department for a Medicaid nursing home permit. The permit will state how many Medicaid patient days the nursing facility may provide, and the nursing facility must provide within ten percent of this number of days of care. As mandated by the Nursing Home Licensing Act of

LONG TERM CARE BED NEED

		2012 POP. 65+(000)	BED NEED (POP.X 39)	EXISTING BEDS	BEDS NEEDED/ EXCESS	TOTAL # BEDS TO BE ADDED
	ANDERSON	27.12	1,058	751	307	307
	CHEROKEE	7.46	291	243	48	48
	GREENVILLE	52.78	2,058	1,838	220	220
	OCONEE	15.59	608	252	356	356
	PICKENS	15.86	619	437	182	182
	SPARTANBURG	37.60	1,466	1,279	187	187
	UNION	5.17	201	201	0	
REGION I	TOTAL	161.57	6,301	5,001	1,300	1,300
	ABBEVILLE	4.35	169	116	53	53
	CHESTER	5.00	195	100	95	95
	EDGEFIELD	3.56	139	120	19	19
	FAIRFIELD	3.60	140	262	-122	
	GREENWOOD	10.07	393	354	39	39
	KERSHAW	8.42	328	244	84	84
	LANCASTER	8.43	329	288	41	41
	LAURENS	11.45	447	420	27	27
	LEXINGTON	31.95	1,246	924	322	322
	MCCORMICK	3.46	135	120	15	15
	NEWBERRY	6.16	240	276	-36	
	RICHLAND	37.66	1,469	1,330	139	139
	SALUDA	3.44	134	176	-42	
	YORK	22.53	878	693	185	185
REGION II	TOTAL	160.04	6,242	5,423	819	1,019
	CHESTERFIELD	5.98	233	224	9	9
	CLARENDON	6.80	265	152	113	113
	DARLINGTON	9.61	375	366	9	9
	DILLON	3.73	145	195	-50	
	FLORENCE	18.21	710	775	-65	
	GEORGETOWN	13.54	528	249	279	279
	HORRY	47.04	1,834	896	938	938
	LEE	3.12	121	120	1	1
	MARION	4.82	188	180	8	8
	MARLBORO	3.48	136	110	26	26
	SUMTER	15.53	605	428	177	177
	WILLIAMSBURG	5.69	222	184	38	38
REGION III	TOTAL	137.52	5,362	3,879	1,483	1,598
	AIKEN	24.67	962	778	184	184
	ALLENDALE	1.88	73	44	29	29
	BAMBERG	2.44	95	88	7	7
	BARNWELL	3.75	146	173	-27	
	BEAUFORT	34.67	1,352	491	861	861
	BERKELEY	22.31	870	355	515	515
	CALHOUN	2.71	105	120	-15	
	CHARLESTON	47.32	1,845	1,288	557	557
	COLLETON	6.12	239	132	107	107
	DORCHESTER	16.31	636	351	285	285
	HAMPTON	3.26	127	104	23	23
	JASPER	3.09	120	88	32	32
	ORANGEBURG	14.98	584	393	191	191
REGION IV	TOTAL	183.48	7,154	4,405	2,749	2,791
STATEWIDE TOTALS		642.61	25,059	18,708	6,351	6,708

NURSING FACILITY BED NEED
TO BE ADDED/EXCESS CIRCLED
AS OF APRIL 20, 2010



COUNTY	2012 POP (000s 65+)	NURSING FACILITY BEDS	BEDS PER 1,000 POP	RANK
BEAUFORT	34.67	491	14.16	1
BERKELEY	22.31	355	15.91	2
OCONEE	15.59	252	16.16	3
GEORGETOWN	13.54	249	18.39	4
HORRY	47.04	896	19.05	5
CHESTER	5.00	100	20.02	6
DORCHESTER	16.31	351	21.53	7
COLLETON	6.12	132	21.57	8
CLARENDON	6.80	152	22.35	9
ALLENDALE	1.88	44	23.47	10
ORANGEBURG	14.98	393	26.23	11
ABBEVILLE	4.35	116	26.70	12
CHARLESTON	47.32	1,288	27.22	13
PICKENS	15.86	437	27.55	14
SUMTER	15.53	428	27.57	15
ANDERSON	27.12	751	27.69	16
JASPER	3.09	88	28.53	17
LEXINGTON	31.95	924	28.92	18
KERSHAW	8.42	244	28.98	19
YORK	22.53	693	30.77	20
AIKEN	24.67	778	31.54	21
MARLBORO	3.48	110	31.65	22
HAMPTON	3.26	104	31.90	23
WILLIAMSBURG	5.69	184	32.37	24
CHEROKEE	7.46	243	32.57	25
EDGEFIELD	3.56	120	33.76	26
SPARTANBURG	37.60	1,279	34.02	27
LANCASTER	8.43	288	34.18	28
MCCORMICK	3.46	120	34.68	29
GREENVILLE	52.78	1,838	34.83	30
GREENWOOD	10.07	354	35.15	31
RICHLAND	37.66	1,330	35.32	32
BAMBERG	2.44	88	36.07	33
LAURENS	11.45	420	36.68	34
MARION	4.82	180	37.34	35
CHESTERFIELD	5.98	224	37.46	36
DARLINGTON	9.61	366	38.11	37
LEE	3.12	120	38.52	38
UNION	5.17	201	38.92	39
FLORENCE	18.21	775	42.56	40
CALHOUN	2.71	120	44.36	41
NEWBERRY	6.16	276	44.84	42
BARNWELL	3.75	173	46.13	43
SALUDA	3.44	176	51.24	44
DILLON	3.73	195	52.28	45
FAIRFIELD	3.60	262	72.78	46
	642.610	18,708	29.11	

1987, as amended, the Department will allocate permits up to the number of Medicaid patient days authorized by the General Assembly.

Medicaid Patient Days and Medicaid Beds Requested and Authorized:

Year	# Days Requested	Beds	# Days Authorized	Beds	# Days Difference
1988-1989	3,032,839	8,309	2,971,811	8,142	61,028
1989-1990	3,644,248	9,984	3,644,248	9,984	0
1990-1991	3,709,814	10,163	3,659,965	10,028	49,849
1991-1992	3,856,833	10.567	3,659,965	10,028	196,868
1992-1993	3,976,576	10,895	3,806,382	10,429	170,194
1993-1994	4,012,359	10,993	3,856,382	10,566	155,977
1994-1995	4,023,690	11,024	3,892,882	10,665	130,808
1995-1996	3,969,681	10,876	3,892,882	10,665	76,799
1996-1997	4,072,519	11,158	4,002,382	10,965	70,137
1997-1998	4,119,753	11,287	4,097,282	11,225	22,471
1998-1999	4,265,182	11,685	4,265,182	11,685	0
1999-2000	4,367,134	11,965	4,341,832	11,895	25,302
2000-2001	4,420,522	12,111	4,378,332	11,995	42,190
2001-2002	4,473,170	12,255	4,275,998	11,715	197,172
2002-2003	4,340,158	11,891	4,205,553	11,522	134,605
2003-2004	4,304,160	11,792	4,205,553	11,522	98,607
2004-2005	4,294,977	11,767	4,205,553	11,522	89,424
2005-2006	4,291,812	11,758	4,205,553	11,522	86,259
2006-2007	4,283,209	11,735	4,205,553	11,522	77,656
2007-2008	4,263,785	11,682	4,205,553	11,522	58,232
2008-2009	4,231,047	11,592	4,205,553	11,522	25,494
2009-2010	4,215,522	11,549	4,205,553	11,522	9,969

C. Community Long Term Care (CLTC) Program:

The South Carolina Community Long Term Care Project (CLTC) provides mandatory pre-admission screening and case management for Medicaid-eligible individuals who are applying for nursing facility placement under the Medicaid program. It also provides the following community-based services for participants who prefer to receive care in the community rather than institutional care:

1. Personal Care;
2. Environmental Modifications;
3. Home-Delivered Meals;
4. Adult Day Health Care (ADHE);
5. Respite Care;
6. Personal Emergency Response System (PERS);
7. Durable Medical Equipment;
8. Nursing Services; and
9. Case Management.

DHHS operates three home and community-based Medicaid waiver programs through the CLTC program. Community Choices was funded for 12,000 slots for FY 07-08; the other waivers serve 1,000 persons with HIV disease and approximately 30 adults who are dependent upon mechanical ventilation. The PACE program is jointly funded by Medicare and provides primary and long-term care services to participants age 55 and older who meet the State's nursing facility level of care. The Palmetto SeniorCare (PSC) Program operates five PACE Centers in Richland and Lexington Counties and served 440 participants during FY 2007. A second PACE site began operation in March 2008 operated by The Oaks CCRC in Orangeburg. DHHS is also participating in a federal initiative called Money Follows the Person, which allows people who have been in a nursing facility for at least six months to transition back to the community.

D. Mental Retardation Facilities:

According to national estimates, three percent of the population is considered to be mentally retarded and one percent is retarded to the extent that special support services and programs are needed.

The South Carolina Department of Disabilities and Special Needs (DDSN) has reduced the bed capacity of its four regional centers (Whitten, Coastal, Midlands, and Pee Dee). Community residential beds have been developed for those persons from the regional centers and those on the residential services waiting list. These beds represent the continuum of programs, which includes community residences, supervised living programs, and community training homes. These programs enable persons with mental retardation to be served in their own communities in the settings they choose to live and receive supports in. DDSN also operates three home and community-based Medicaid waiver programs for the following target groups: Mental Retardation and Related Disabilities, Head and Spinal Cord Injuries, and Pervasive Developmental Disorders.

E. Institutional Nursing Facility (Retirement Community Nursing Facility):

An institutional nursing facility means a nursing facility (established within the jurisdiction of a larger non-medical institution) that maintains and operates organized facilities and services to accommodate only students, residents or inmates of the institution. A bed need for this category has been established in order to provide necessary services for retirement communities as established by church, fraternal, or other organizations. Such beds must serve only the residents of the housing complex and either be developed after the housing has been established or be developed as a part of a total housing construction program that has documented that the entire complex is one inseparable project.

To be considered under this special bed category, the following criteria must be met:

1. The nursing facility must be a part of and located on the campus of the retirement community.

2. It must restrict admissions to campus residents.

3. The facility may not participate in the Medicaid or Medicare programs.

There is no projection of need for this bed category. The applicant must demonstrate that the proposed number of beds is justified and that the facility meets the above qualifications. If approved by the Department, such a facility would be licensed as an "Institutional Nursing Home," and the beds generated by such a project will be placed in the statewide inventory in Chapter III. These beds are not counted against the projected need of the county where the facility is located. For established retirement communities, a generally accepted ratio of nursing facility beds to retirement beds is 1:4. However, this ratio may high for a newly established retirement center as new residents are typically not in need of nursing facility care as soon as the facility is licensed. The nursing facility could operate at low utilization for the first several years.

Relative Importance of Project Review Criteria

The following project review criteria, as outlined in Chapter 8 of Regulation 61-15, are considered the most important in evaluating Certificate of Need applications for these beds or facilities:

a. Need for the Proposed Project;
b. Economic Consideration; and
c. Health System Resources.

Because Institutional Nursing Facility Beds are used solely by the residents of the retirement community, there is no justification for approving this type of nursing facility unless the need can be documented by the retirement center. The benefits of improved accessibility do not outweigh the adverse effects caused by the duplication of any existing beds or facilities.

F. Swing Beds:

A Certificate of Need is not required to participate in the Swing Bed Program in South Carolina. However, the hospital must be certified to participate in Medicare.

The Social Security Act (Section 1883(a)(1), [42 U.S.C. 1395tt] permits certain small, rural hospitals to enter into a swing bed agreement, under which the hospital can use its beds to provide either acute or SNF care, as needed. The hospital must be located in a rural area and have fewer than 100 beds. The Code of Federal Regulations (CFR) section 42 details the other specific program requirements

Medicare Part A covers the services furnished in a swing bed hospital under the SNF PPS. The PPS classifies residents into one of 44 categories for payment purposes. To qualify for SNF-level services, a beneficiary is required to receive acute care as a hospital inpatient for a stay of at least three consecutive days, although it does not have to be from the same hospital as the swing bed. Typical medical criteria include daily physical, occupational and/or speech therapy, IV or nutritional therapy, complex wound treatment, pain management, and end-of-life care.

The following hospitals in South Carolina participated in the swing bed program during 2008:

Hospital		Swing Beds	Admissions	Patient Days	Average Census
Abbeville Area Medical Ctr.		25	43	422	1.2
Allendale County Hospital		15	78	3,371	9.2
Bamberg County Memorial	*1*	24			
Chesterfield General		48	81	520	1.4
Coastal Carolina		10	16	87	0.3
Edgefield Co. Hospital		25	130	1,075	2.9
Fairfield Memorial	*1*	25			
Marlboro Park Hospital		6	61	315	0.9
McLeod-Darlington		24	71	6,296	17.2
Wallace Thompson	*1*	12			
Williamsburg Regional	*1*	10			
TOTALS		224	480	12,086	33.0

1 Participates in the program but did not use the beds in 2008.

G. Hospice Facilities and Hospice Programs:

Hospice is a centrally administered, interdisciplinary health care program, which provides a continuum of medically supervised palliative and supportive care for the terminally ill patient and the family or responsible party, including, but not limited to home, outpatient and inpatient services

provided directly or through written agreement. Inpatient services include, but are not limited to, services provided by a hospice in a licensed hospice facility.

A Hospice Facility means an institution, place or building licensed by the Department to provide room, board and appropriate hospice care on a 24-hour basis to individuals requiring such services pursuant to the orders of a physician.

A Hospice Program means an entity licensed by the Department that provides appropriate hospice care to individuals as described in the first paragraph above, exclusive of the services provided by a hospice facility.

The existing and approved inpatient hospices in South Carolina are listed on the following page.

Certificate of Need Standards

1. A Certificate of Need is only required for an Inpatient Hospice Facility; it is not required for the establishment of a Hospice Program.

2. An Inpatient Hospice Facility must be owned or operated either directly or through contractual agreement with a licensed hospice program.

3. The applicant must document the need for the facility and justify the number of inpatient beds that are being requested.

4. The proposed facility must consider the impact on other existing inpatient hospice facilities.

Relative Importance of Project Review Criteria

The following Project Review Criteria are considered to be the most important in evaluating Certificate of Need applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Distribution (Accessibility);
c. Community Need Documentation;
d. Acceptability;
e. Financial feasibility; and
f. Staff Resources.

Ninety-four licensed Hospice Programs exist with at least one licensed hospice serving every county in the state. Additional information may be found at http://www.scdhec.net/health/hrreg.htm. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

INPATIENT HOSPICES, 2008 DATA

NAME OF FACILITY	COUNTY	LICENSED BEDS	ADMISSIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
REGION I						
CALLIE & JOHN RAINEY HOSPICE HOUSE	ANDERSON	32	643	8,265	32	70.6%
MCCALL HOSPICE HOUSE OF GREENVILLE	GREENVILLE	30	416	6,004	30	54.7%
OCONEE MEMORIAL HOSPICE FOOTHILLS	OCONEE	15	196	2,641	15	48.1%
HOSPICE HOUSE OF CAROLINA FOOTHILLS	SPARTANBURG	12	—	—	—	—
SPARTANBURG REG HEALTHCARE HOSPICE	SPARTANBURG	15	636	4,352	15	79.3%
TOTAL		104	1,891	21,262	92	63.1%
REGION II						
HOSPICE HOUSE OF HOSPICECARE PIEDMONT	GREENWOOD	15	351	3,183	15	58.0%
HOSPICE OF LAURENS CO INPT HOSPICE HOUSE	LAURENS	12	15	122	1.9	17.5%
HEARTLAND HOSPICE HOUSE MIDLANDS	RICHLAND	12	141	1,976	12	45.0%
ASCENSION HOUSE	RICHLAND	14	418	2,815	14	54.9%
HOSPICE AND COMMUNITY CARE	YORK	16	194	1,826	16	31.2%
TOTAL		69	1,119	9,922	58.9	46.0%
REGION III						
MCLEOD HOSPICE HOUSE *1*	FLORENCE	24	452	3,789	12	86.3%
TIDELANDS COMMUNITY HOSPICE HOUSE	GEORGETOWN	12	187	1,725	12	39.3%
AGAPE HOSPICE HOUSE OF HORRY COUNTY	HORRY	24	—	—	—	—
TOTAL		60	639	5,514	24	62.8%
REGION IV						
THE HOSPICE OF CHARLESTON	CHARLESTON	20	538	5,413	20	74.2%
TOTAL		20	538	5,413	20	74.2%
STATEWIDE TOTAL		**253**	**4,187**	**42,111**	**195**	**45.5%**

1 CON approved 2/23/10 to add 12 beds for a total of 24.

H. Home Health

1. Home Health Agencies:

Home Health Agency means a public, nonprofit, or proprietary organization, whether owned or operated by one or more persons or legal entities, which furnishes or offers to furnish home health services. Home health services means those items and services furnished to an individual by a home health agency, or by others under arrangement with the home health agency, on a visiting basis and except for (f) below, in a place of temporary or permanent residence used as the individual's home as follows:

Part-time or intermittent skilled nursing care as ordered by a physician or podiatrist and provided by or under the supervision of a registered nurse and at least one other therapeutic service listed below: (a) physical, occupational, or speech therapy; (b) medical social services; (c) home health aide services; (d) other therapeutic services; (e) medical supplies as indicated in the treatment plan and the use of medical appliances, to include durable medical equipment and (f) any of the above items and services provided on an outpatient basis under arrangements made by the home health agency with a hospital, nursing home or rehabilitation center and the furnishing of which involves the use of equipment of such a nature that the items/services cannot readily be made available to the individual in his/her home, or which are furnished at one of the above facilities while the patient is there to receive such items or services. Transportation of the individual in connection with any such items or services is not included.

The average mix of home health visits by type of service during FY 2008 for the home health agencies in South Carolina were:

Total Visits	1,796,458
Nursing Visits	44.3%
Home Health Aide Visits	9.0%
Physical Therapy Visits	34.9%
Medical Social Worker Visits	2.3%
Speech Therapy Visits	1.4%
Occupational Therapy Visits	8.0%
Other	0.1%

Nursing visits includes all visits provided by a nurse including IV therapy and chemotherapy.

Under the Balanced Budget Act of 1997, Medicare changed to a Prospective Payment System (PPS) for home health services. Patients are assessed and assigned to one of 80 Home Health Resource Groups (HHRGs); agencies then receive a fixed payment for a 60-day episode of care, regardless of the number of visits provided. As a result, the number of visits per patient has decreased from 45.7 in 1997 to 18.9 in 2008. In 2007, CMS revised its policy on "case mix," which was expected to make a nearly 12% reduction in the national 60-day standardized payment rate by 2011 and decrease home health expenditures by $7 billion over that time.

Of the patients currently receiving home health services, approximately 34% are less than age 65 and 66% are age 65 and over. Some agencies are licensed to serve broad geographic areas, yet provide services to less than 50 patients annually in some counties in their licensed service area. Unless a need for another agency is indicated, the existing agencies should be able to expand their staff to meet any additional need.

Certificate of Need Standards

1. An applicant must propose home health services to cover the geographic area of an entire county and agree to serve residents throughout the entire county.

2. A separate application is required for each county in which services are to be provided.

3. There should be documentation from physicians and discharge planners in the proposed service area substantiating the need and support for an additional home health agency. These need and support letters must be on letterhead and define which practice and specialty or facility the physician/discharge planner represents as well as the county from which their patient base will be drawn. They must clearly state the number of additional patients that will be referred to a new home health agency and why another home health agency is needed. The physician or discharge planner must also personally sign these letters. If there are problems with the existing agencies serving the area, the physicians and discharge planners should state the reasons.

4. The need methodology creates use rates for four population groups (0-14, 15-64, 65-74, 75+) and applies them against the estimated populations for each county to get a total number of estimated patients in need. It then takes the current actual number of patients served by county and multiplies them by the projected population growth to project the number of patients to be served by the home health agencies in the county. The projected number of patients served is subtracted from the estimated number of patients in need. If there is a difference of greater than 50 patients projected to be in need, then another agency could be approved for that county.

5. The applicant should have a track record that demonstrates a commitment to quality services. There should be no history of prosecution, loss of license, consent order, or abandonment of patients in other business operations. The applicant must provide a list of all licensed home health agencies it operates and the state(s) where it operates them.

6. The applicant must document that it can serve at least 50 patients annually in each county for which it is licensed within two years of initiation of services. The applicant must assure the Department that, should they fail to provide home health services to fewer than 50 patients annually for a county two years after initiation of services, they will voluntarily relinquish the license for that county. If an agency's license is terminated, another agency will be approved only if the methodology indicates the projected need for an additional agency.

Quality

CMS initiated a national home health quality improvement campaign in January 2010. The Home Health Quality Improvement (HHQI) initiative is designed to reduce avoidable hospitalizations and improve medication management. The campaign will provide resources and best practice education to participating HHAs. The South Carolina Home Care & Hospice Association (SCHCA) is serving as the Local Area Network for Excellence (LANE) to create campaign awareness and recruit participants.

While this is a voluntary campaign, the Department encourages all licensed Home Health Agencies to participate.

2. Pediatric Home Health Agencies:

Due to the limited number of home health providers available to treat children 14 years or younger, an exception to the above criteria may be made for a CON for a Home Health Agency restricted to providing intermittent home health skilled nursing services to patients 14 years or younger. The license for the agency will be restricted to serving children 14 years or younger and will ensure access to necessary and appropriate intermittent home health skilled nursing services to these patients. Any such approved agency will not be counted in the county inventories for need projection purposes.

Certificate of Need Standards

1. A separate CON application will be required for each county for an agency that proposes to provide this specialized service to pediatric patients in multiple counties.

2. The applicant must document that no other agency offers this service in the county of application, and the agency will limit such services to the pediatric population 14 years or younger.

3. Continuing Care Retirement Community Home Health Agencies:

A licensed continuing care retirement community that also incorporates a skilled nursing facility may provide home health services and is exempt from Certificate of Need provided:

1. The continuing care retirement furnishes or offers to furnish home health services only to residents who reside in living units provided by the continuing care retirement community pursuant to a continuing care contract;

2. The continuing care retirement community maintains a current license and meets the applicable home health agency licensing standards; and

3. Residents of the continuing care retirement community may choose to obtain home health services from other licensed home health agencies.

Staff from other areas of the continuing care retirement community may deliver the home health services, but at no time may staffing levels in any area of the continuing care retirement community fall below minimum licensing standards or impair the services provided. If the continuing care retirement community includes charges for home health services in its base contract, it is prohibited from billing additional fees for those services. Continuing care retirement communities certified for Medicare or Medicaid, or both, must comply with government reimbursement requirements concerning charges for home health services. The continuing care retirement community shall not bill in excess of its costs. These costs will be determined on non-facility-based Medicare and/or Medicaid standards. Because these continuing care retirement community home health agencies serve only residents of the retirement community, these facilities are not counted in the county need projections.

Relative Importance of Project Review Criteria

The following project review criteria, as outlined in Chapter 8 of Regulation 61-15, are considered to be the most important in reviewing CON applications for this service:

a. Compliance with the Need Outlined in this Section of the Plan;
b. Acceptability;
c. Distribution (Accessibility);
d. Medically Underserved Groups;
e. Record of the Applicant; and
f. Financial Feasibility.

Because home health agencies provide services in every county and there are at least two providers per county, there is no justification for approving additional agencies beyond those shown as needed in this Plan. The benefits of improved accessibility do not outweigh the adverse effects caused by the duplication of any existing service.

HOME HEALTH AGENCY METHODOLOGY

County	Projected 2010 Pop Age 0 to 14	Estimated Pts	Projected 2010 Pop Age 15 to 64	Estimated Pts	Projected 2010 Pop Age 65 to 74	Estimated Pts	Projected 2010 Pop Age 75 to 99	Estimated Pts	Total Estimated Pts	2008 Actual Pts.	Growth Factor	Total Projected Pts	2010 Unmet Need	Projected Need for New HHA
Abbeville County	5,520	22	17,940	90	2,290	103	1,900	352	566	892	1.016	906	(340)	NO
Aiken County	30,450	122	110,380	552	12,890	580	10,220	1,891	3,144	2,187	1.025	2,242	903	NO
Allendale County	2,510	10	7,690	38	980	44	770	142	235	80	1.003	80	155	**YES**
Anderson County	35,250	141	119,210	596	15,070	678	10,750	1,989	3,404	3,251	1.018	3,310	94	**YES**
Bamberg County	3,020	12	10,390	52	1,370	62	970	179	305	197	0.991	195	110	**YES**
Barnwell County	4,950	20	16,960	85	1,910	86	1,580	292	483	526	1.018	535	(53)	NO
Beaufort County	22,390	90	93,000	465	18,570	836	12,460	2,305	3,695	2,610	1.039	2,712	984	**YES**
Berkeley County	34,550	138	113,210	566	12,320	554	7,440	1,376	2,635	2,323	1.027	2,386	249	**YES**
Calhoun County	2,810	11	11,040	55	1,540	69	950	176	311	229	1.018	233	78	**YES**
Charleston County	59,430	238	225,090	1,125	25,620	1,153	18,420	3,408	5,924	8,228	1.010	8,310	(2,387)	NO
Cherokee County	12,180	49	38,550	193	4,180	188	2,940	544	973	1,361	1.022	1,391	(417)	NO
Chester County	7,310	29	23,370	117	2,790	126	2,030	376	647	714	1.010	721	(74)	NO
Chesterfield County	9,060	36	29,590	148	3,440	155	2,180	403	742	836	1.010	844	(102)	NO
Clarendon County	6,260	25	22,180	111	3,910	176	2,300	426	737	715	1.016	726	11	NO
Colleton County	8,830	35	27,050	135	3,520	158	2,210	409	738	1,016	1.017	1,033	(295)	NO
Darlington County	14,330	57	45,920	230	5,530	249	3,470	642	1,178	1,274	1.008	1,284	(106)	NO
Dillon County	6,610	26	20,150	101	2,150	97	1,380	255	479	672	1.003	674	(195)	NO
Dorchester County	22,330	89	78,630	393	8,580	386	5,920	1,095	1,964	2,268	1.032	2,341	(377)	NO
Edgefield County	4,650	19	19,550	98	1,920	86	1,280	237	440	281	1.030	289	150	**YES**
Fairfield County	5,060	20	16,640	83	1,950	88	1,350	250	441	487	1.011	492	(51)	NO
Florence County	26,530	106	91,010	455	9,820	442	7,110	1,315	2,318	2,789	1.013	2,825	(507)	NO
Georgetown County	10,450	42	38,980	195	7,550	340	4,770	882	1,459	1,841	1.023	1,883	(424)	NO
Greenville County	81,690	327	289,570	1,448	28,980	1,304	20,970	3,879	6,958	8,086	1.023	8,272	(1,314)	NO
Greenwood County	14,550	58	47,000	235	5,470	246	4,150	768	1,307	2,145	1.015	2,177	(870)	NO
Hampton County	4,460	18	15,200	76	1,770	80	1,260	233	407	484	1.016	492	(85)	NO
Horry County	35,610	142	160,450	802	26,460	1,191	16,540	3,060	5,195	6,104	1.040	6,348	(1,153)	NO
Jasper County	4,110	16	16,060	80	1,640	74	1,190	220	391	393	1.029	404	(14)	NO
Kershaw County	11,510	46	39,480	197	4,570	206	3,350	620	1,069	1,173	1.025	1,202	(133)	NO
Lancaster County	12,610	50	43,380	217	4,980	224	2,990	553	1,045	1,403	1.013	1,421	(377)	NO
Laurens County	14,110	56	52,360	262	6,280	283	4,490	831	1,431	1,661	1.024	1,701	(269)	NO
Lee County	4,180	17	13,880	69	1,540	69	1,440	266	422	328	1.011	332	90	**YES**
Lexington County	48,390	194	174,800	874	16,860	759	12,550	2,322	4,148	4,683	1.032	4,833	(685)	NO
Marion County	7,510	30	24,250	121	2,780	125	1,830	339	615	279	1.003	280	335	**YES**
Marlboro County	5,800	23	18,300	92	2,040	92	1,300	241	447	764	0.990	756	(309)	NO
McCormick County	1,230	5	7,020	35	1,970	89	1,070	198	327	608	1.020	620	(294)	NO
Newberry County	7,340	29	25,400	127	3,300	149	2,480	459	764	883	1.013	894	(131)	NO
Oconee County	13,070	52	47,860	239	8,890	400	5,640	1,043	1,735	1,956	1.025	2,005	(270)	NO
Orangeburg County	19,010	76	63,820	319	8,140	366	5,910	1,093	1,855	2,588	1.011	2,616	(762)	NO
Pickens County	22,330	89	89,910	450	8,680	391	6,230	1,153	2,082	2,399	1.027	2,464	(382)	NO
Richland County	64,830	259	246,020	1,230	20,190	909	14,680	2,716	5,114	5,844	1.016	5,938	(824)	NO
Saluda County	3,730	15	13,070	65	1,810	81	1,460	270	432	376	1.014	381	51	**YES**
Spartanburg County	54,620	218	190,490	952	21,030	946	14,460	2,675	4,792	5,671	1.019	5,779	(986)	NO
Sumter County	25,780	103	75,660	378	8,210	369	6,470	1,197	2,048	2,342	1.014	2,375	(327)	NO
Union County	5,780	23	18,650	93	2,640	119	2,360	437	672	995	0.994	989	(317)	NO
Williamsburg County	7,660	31	23,900	120	3,160	142	2,140	396	688	800	0.999	799	(111)	NO
York County	36,680	147	134,710	674	12,390	558	8,520	1,576	2,954	3,904	1.032	4,029	(1,075)	NO

HOME HEALTH UTILIZATION, 1980-2008

YEAR	PATIENTS SERVED	TOTAL VISITS	VISITS/ PATIENT
1980	17,120	------	------
1981	18,021	------	------
1982	19,751	------	------
1983	24,013	427,759	17.8
1984	28,511	590,657	20.7
1985	30,360	631,498	20.8
1986	21,012	672,361	32.0
1987	30,004	673,346	22.4
1988	31,230	710,756	22.8
1989	32,727	843,514	25.8
1990	36,827	1,024,177	27.8
1991	41,912	1,307,371	31.2
1992	49,035	1,767,825	36.1
1993	55,551	2,417,241	43.5
1994	65,754	3,192,689	48.6
1995	77,214	3,755,027	48.6
1996	86,070	3,995,110	46.4
1997	88,711	4,055,843	45.7
1998	86,123	3,131,997	36.4
1999	83,969	2,472,078	29.4
2000	78,542	2,041,754	26.0
2001	77,869	1,427,436	18.3
2002	84,192	1,290,991	15.3
2003	81,708	1,235,335	15.1
2004	82,971	1,291,738	15.6
2005	81,754	1,454,745	17.8
2006	82,897	1,537,455	18.5
2007	89,851	1,644,773	18.3
2008	91,724	1,796,458	19.6

Home Health Agency Utilization 2008

Agency	Counties Served	Persons Served	Total Visits	Visits/ Person
Alere Womens & Childrens-Midlands *1* (may serve obstetrical patients only)	Berkeley, Charleston, Colleton, Dorchester, Aiken, Beaufort, Fairfield, Georgetown, Kershaw, Lancaster, Lexington, Newberry, & Richland	379	584	1.5
Alere Womens & Childrens-Piedmont *2* (may serve obstetrical patients only)	Anderson, Cherokee, Chesterfield, Greenville, Oconee, Pickens, Spartanburg, York, Abbeville, Allendale, Bamberg, Barnwell, Calhoun, Chester, Clarendon, Darlington, Dillon, Edgefield, Florence, Greenwood, Hampton, Horry, Jasper, Laurens, Lee, Marion, Marlboro, McCormick, Sumter, Orangeburg, Saluda, Union & Williamsburg	427	670	1.6
Amedysis Home Health of Camden	Calhoun, Fairfield, Kershaw, Lexington, Newberry, Orangeburg & Richland	740	13,067	17.7
Amedysis Home Health of Clinton	Abbeville, Greenville, Greenwood & Laurens	1,644	32,495	19.8
Amedysis Home Health of Conway	Horry	1,279	24,985	19.5
Amedysis Home Health of Charleston	Berkeley, Charleston & Dorchester	3,527	68,913	19.5
Amedysis Home Health Georgetown	Georgetown & Williamsburg	1,589	28,325	17.8
Amedysis HH Georgetown East	Georgetown & Williamsburg	168	2,436	14.5
Amedisys Home Health Hilton Head	Beaufort and Jasper	938	18,486	19.7
Amedysis Home Health of Lexington	Calhoun, Edgefield, Lee, Lexington, Newberry, Orangeburg, Richland & Sumter	5,523	108,699	19.7
Amedysis Home Health Myrtle Beach	Horry	1,158	18,259	15.8
Amedysis Home Health of North Charleston	Berkeley, Charleston, Colleton, Dorchester, & Hampton	4,288	75,100	17.5
AnMed Health Home Health	Anderson	1,201	24,736	20.6
Beaufort-Jasper Home Health Agency	Beaufort & Jasper	172	4,649	27.0
Bethea Home Health (may serve retirement community only)	Darlington	27	20,759	768.9
Brightwater Home Health *3* (may serve retirement community only)	Horry			
Care One Home Health	Beaufort, Hampton & Jasper	716	13,302	18.6
CarePro Home Health	Richland & Sumter	484	9,205	19.0
Caring Neighbors Home Health	Fairfield	266	3,977	15.0
Carolina Home Health Care	Lexington & Richland	1,749	31,005	17.7

Carolina Home Health Care Greenville (may only serve patients in Union Co. with initial diag requiring IV therapy and/or home uterine activity monitoring)	Anderson, Cherokee, Greenville, Laurens, Oconee, Pickens, Spartanburg & Union	3,019	63,536	21.0
Carolinas Home Health *4*	Darlington, Dillon, Florence & Marlboro	1,486	30,262	20.4
Chesterfield Visiting Nurses Services	Chesterfield, Darlington & Marlboro	425	10,374	24.4
Clarendon Memorial Home Health	Clarendon	366	4,928	13.5
Clemson Area Retirement Ctr HH (may serve retirement community only)	Pickens	26	4,770	183.5
Cypress Club Home Health Agency (may serve retirement community only)	Beaufort	62	3,633	58.6
DHEC Region 1 Home Health	Abbeville, Anderson, Edgefield, Greenwood, Laurens, McCormick, Oconee & Saluda	879	22,271	25.3
DHEC Region 2 Home Health West	Greenville & Pickens	569	8,817	15.5
DHEC Region 2 Home Health East	Cherokee, Spartanburg & Union	513	10,077	19.6
DHEC Region 3 Home Health	Chester, Fairfield, Lancaster, Lexington, Newberry, Richland & York	954	14,253	14.9
DHEC Region 4 Home Health East	Chesterfield, Darlington, Dillon, Florence, Marion & Marlboro	1,859	32,287	17.4
DHEC Region 4 Home Health West	Clarendon, Kershaw, Lee & Sumter	873	16,292	18.7
DHEC Region 5 Home Health	Aiken, Allendale, Bamberg, Barnwell, Calhoun & Orangeburg	934	16,237	17.4
DHEC Region 6 Home Health	Georgetown, Horry & Williamsburg	503	7,962	15.8
DHEC Region 7 Home Health	Berkeley, Charleston & Dorchester	555	13,524	24.4
DHEC Region 8 Home Health	Colleton & Hampton	453	6,349	14.0
Florence Visiting Nurses Services	Dillon, Florence, Lee & Marion	335	7,768	23.2
Franklin C. Fetter Home Health Agency	Charleston	154	4,969	32.3
Greenville Hospital System HHA	Greenville & Pickens	1,886	27,357	14.5
Health Related Home Care	Abbeville, Greenwood, Laurens, McCormick & Saluda	1,635	50,653	31.0
HomeCare of HospiceCare Piedmont (may only serve terminally ill Saluda County patients)	Abbeville, Greenwood, Laurens, McCormick & Saluda	25	719	28.8
Home Care of Lancaster	Lancaster	1,168	34,700	29.7
Home Care of the Regional Medical Ctr	Calhoun & Orangeburg	829	25,336	30.6
Home Health of S.C. - Lowcountry	Berkeley & Dorchester	448	7,334	16.4
Home Health of S.C. - Midlands	Lexington & Richland	1,082	18,632	17.2

Home Health of S.C.	York	883	19,517	22.1
Home Health Services of Self Regional Healthcare	Abbeville, Greenwood, Laurens, McCormick & Saluda	1,778	38,670	21.7
Hospice Care of Low Country HH (may serve terminally ill patients only)	Beaufort & Jasper	19	344	18.1
Hospice of Charleston	Berkeley, Charleston & Dorchester	27	497	18.4
Incare Home Health	Georgetown & Horry	1,729	23,936	13.8
Interim HealthCare *5* (restricted to pediatric patients only)	Berkeley, Charleston & Dorchester			
Interim HealthCare of Greenville 147160	Anderson, Cherokee, Greenville, Oconee, Pickens & Spartanburg	8,351	147,140	17.6
Interim HealthCare of Rock Hill	York	1,528	25,060	16.4
Intrepid USA Healthcare Services	Allendale, Berkeley, Charleston, Colleton, Dorchester & Georgetown	1,486	26,356	17.7
Island Health Care	Beaufort	1,294	23,342	18.0
Kershaw County Medical Ctr Home Health	Kershaw	725	16,806	23.2
Lakes at Litchfield *6* (may serve retirement community only)	Georgetown	2	71	35.5
Liberty Home Care - Aiken	Aiken	344	5,142	14.9
Liberty Home Care - Bennettsville	Marlboro	276	4,278	15.5
Liberty Home Care - Myrtle Beach	Horry	885	12,952	14.6
McLeod Home Health	Darlington, Dillon, Florence, Lee & Marion	2,655	46,502	17.5
Methodist Oaks Campus Home Health *7* (may serve retirement community only)	Orangeburg			
Methodist Manor Home Health *8* (may serve retirement community only)	Florence			
NHC HomeCare - Aiken	Aiken	528	19,501	36.9
NHC HomeCare - Greenwood	Greenwood	256	11,701	45.7
NHC HomeCare - Laurens	Greenville & Laurens	865	28,892	33.4
Neighbors Care Home Health Agency	Chester	222	3,596	16.2
Oconee Memorial Home Health	Anderson, Oconee & Pickens	680	20,761	30.5
Palmetto Health HomeCare (terminally ill Bamberg Co. patients only)	Bamberg, Lexington & Richland	1,403	30,477	21.7
PHC Home Health	Charleston	485	15,376	31.7
Roper-St. Francis Home Health Care	Berkeley, Charleston & Dorchester	2,734	54,411	19.9

Sandpiper Home Health Services (may serve retirement community only)	Charleston	23	208	9.0
Sea Island Home Health	Charleston & Colleton	58	5,912	101.9
Spartanburg Reg Med Ctr Home Health	Spartanburg	1,990	34,012	17.1
St. Francis Hospital Home Care	Anderson, Greenville, Pickens & Spartanburg	2,251	35,105	15.6
Seabrook Wellness & Home Health Care (may serve retirement community only)	Beaufort	30	2,234	74.5
Still Hopes Solutions for Living at Home *9* (may serve retirement community only)	Lexington			
Summit Hills Home Health Agency *10* (may serve retirement community only)	Spartanburg			
Total Care of North Carolina - Rock Hill	Cherokee, Chester, Union & York	3,333	57,980	17.4
Total Care - Coastal	Georgetown, Horry & Williamsburg	1,420	24,045	16.9
Tri-County Home Health Care *11*	Lexington, Richland, Saluda & Sumter	3,151	57,614	18.3
Trinity Home Service Home Health	Aiken, Barnwell & Edgefield	754	12,107	16.1
Tuomey Home Health (may only serve terminally ill patients in Lee & Clarendon Counties)	Clarendon, Lee & Sumter	839	12,334	14.7
University Home Health North Augusta	Aiken & Edgefield	944	14,538	15.4
VNA of Greater Bamberg	Allendale, Bamberg, Barnwell, Calhoun, Colleton, Hampton & Orangeburg	420	18,811	44.8
Wesley Commons Home Health Care *12* (may serve retirement community only)	Greenwood	10	387	38.7
Westminster Campus Home Health *13* (may serve retirement community only)	York	33	3,151	95.5
		91,724	1,796,458	

Home Health Agency Footnotes

1 Name changed, formerly Matria Healthcare-Midlands.
2 Name changed, formerly Matria Healthcare-Piedmont.
3 Licensed 9/16/09.
4 Name changed, formerly Home Health Services of Carolina Hospital System.
5 CONs issued for HHA restricted to pediatric patients only, 12/10/09, SC-09-50, SC-09-51, SC-09-52. Licensed 3/2/10.
6 Licensed 5/7/08.
7 Licensed 2/1/08.
8 Licensed 212/10.
9 Licensed 12/17/07.
10 Licensed 5/14/09.
11 CON approved for Aiken County; appealed.
12 Licensed 2/8/08.
13 Licensed 1/23/08.

CHAPTER XIII

STATE SUMMARY

PROGRAM OF EACH REGION

Regional Need and Narrative
Regional Summary and Program
Inventory of Inpatient Facilities
Inventory of Emergency Facilities and Trauma Centers

This chapter inventories all facilities by either statewide region or inventory region and includes the utilization data of the facilities. All changes that have occurred since the previous Plan are explained by a footnote. The numbers of existing and approved beds are summarized by region. The inventory of beds and facilities was current as of April 20, 2010.

DETERMINATION OF REGION NEED AND NARRATIVE

REGION: STATEWIDE FISCAL YEAR: 2008

1. Statewide Health Facilities: The medical facilities serving the entire state are included in this section. These facilities tend to serve restricted use population groups as well as populations with unique needs. Due to fluctuations in the population groups served by these facilities, these types of facilities will be evaluated on an individual basis should an expansion of services or creation of new services or facilities be requested. This Plan recognizes that the needs of the Department of Mental Health and Department of Disabilities and Special Needs may change as the client population changes, since they cannot refuse any client assigned to them by the courts. Therefore, renovation, replacement, and expansion of component programs should be allowed. Because of special conditions placed on the Department of Juvenile Justice by the courts, their patients/clients must be placed in the appropriate alternative setting. Since these patients/clients are to be placed elsewhere within the State system, the State agency responsible for their care should be allowed to develop these alternative programs by contracting with a private provider, by allowing a private provider to construct a facility for these patients/clients or by the conversion/ construction of their own facilities. Facilities that have a contract with the State to serve such individuals will be approved and counted in the statewide category. Facilities owned and operated by the Department of Mental Health and the Department of Disabilities and Special Needs are exempt from Certificate of Need review except an addition of one or more beds to the total number of beds existing as of July 1, 1988. The Department of Mental Health had 3,720 and the Department of Disabilities and Special Needs had 3,100 beds. The William J. McCord Adolescent Treatment Center continues to have an occupancy rate of greater than 90% and should be allowed to increase the number of beds for adolescents. The facility will justify the need for additional beds and obtain the support of the Department of Alcohol and Other Drug Abuse Services.

2. All changes affecting the Statewide Health Facilities have been fully annotated in the inventory.

REGION: STATEWIDE **INPATIENT INVENTORY** **FISCAL YEAR 2008**

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS
	HOSPITALS:								
	THE CITADEL INFIRMARY		CHARLESTON	CHARLESTON	ST	38	38		
	LIEBER CORRECTIONAL INST INFIRMARY		DORCHESTER	RIDGEVILLE	ST	10	10		
X	SHRINERS HOSPITAL FOR CHILDREN		GREENVILLE	GREENVILLE	NPA	50	50	1,180	3,607
	W.J. BARGE MEMORIAL HOSPITAL		GREENVILLE	GREENVILLE	NPA	79	90		
	LEE CORRECTIONAL INSTITUTE INF		LEE	BISHOPVILLE	ST	20	20		
	SC VOC REHAB EVALUATION CTR		LEXINGTON	W COLUMBIA	ST	30	30	526	302
	COLUMBIA REGIONAL CARE CENTER	1	RICHLAND	COLUMBIA	PROP	196	198	242	62,677
XYZ	MORRIS VILLAGE		RICHLAND	COLUMBIA	ST	11	11		
	KIRKLAND CORRECTIONAL INFIRMARY		RICHLAND	COLUMBIA	ST	24	24		
	WILLOW LANE INFIRMARY		RICHLAND	COLUMBIA	ST	8	8		
	CHILDREN'S HABILITATION CENTER		SPARTANBURG	SPARTANBURG	ST	22	22	299	299
	TOTAL					**450**	**463**	**2,247**	**66,885**
	MENTAL HOSPITALS:								
XYZ	PATRICK B HARRIS PSYCHIATRIC		ANDERSON	ANDERSON	ST	200	200	1,142	51,678
XYZ	COLUMBIA CARE CENTER	2	RICHLAND	COLUMBIA	PROP	178	178	294	53,392
XYZ	CRAFTS FARROW FORENSIC BUILDING	3	RICHLAND	COLUMBIA	ST	0	0		
XYZ	G WERBER BRYAN PSYCHIATRIC HOSP	2	RICHLAND	COLUMBIA	ST	492	492	850	82,400
	GILLIAM PSYCHIATRIC HOSPITAL		RICHLAND	COLUMBIA	ST	87	87		
XYZ	SC STATE HOSPITAL	4	RICHLAND	COLUMBIA	ST	144	501		
XYZ	WILLIAM S HALL PSYCHIATRIC INSTITUTE		RICHLAND	COLUMBIA	ST	89	89	344	7,154
	TOTAL					**1,190**	**1,547**	**2,630**	**194,624**
	RESIDENTAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS:								
XYZ	DIRECTIONS - WILLIAM S HALL		RICHLAND	COLUMBIA	ST	37	37	42	7,499
	TOTAL					**37**	**37**	**42**	**7,499**
	DRUG & ALCOHOL INPT TREATMENT:								
	PALMETTO CENTER		FLORENCE	FLORENCE	ST	48	48		
	HOMESVIEW ALCOHOLIC CTR		GREENVILLE	GREENVILLE	ST	36	36		
XYZ	WM J MCCORD ADOLESCENT TREAT		ORANGEBURG	ORANGEBURG	ST	15	15	162	5,285
XYZ	WILLIAM S HALL		RICHLAND	COLUMBIA	ST	19	19	44	5,377
XYZ	MORRIS VILLAGE		RICHLAND	COLUMBIA	ST	163	163	1,797	47,775
	TOTAL					**281**	**281**	**2,003**	**58,437**
	LONG TERM FACILITIES:								
Y	RICHARD M CAMPBELL VA NURS HOME		ANDERSON	ANDERSON	ST	220	220	115	76,104
YN	PRESTON HEALTH CENTER		BEAUFORT	HILTON HEAD	PROP	8	8	15	1,763
Y	FRASER HEALTH CENTER		BEAUFORT	HILTON HEAD	PROP	14	14	42	4,303
Y	BISHOP GADSDEN EPISCOPAL		CHARLESTON	CHARLESTON	NPA	9	9	9	3,015
N	THE FRANKE HEALTH CARE CTR		CHARLESTON	MT PLEASANT	NPA	20	20	36	6,875

REGION: STATEWIDE **INPATIENT INVENTORY** **FISCAL YEAR 2008**

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS
	VETERANS VICTORY HOUSE		COLLETON	WALTERBORO	ST	220	220	181	68,030
N	BETHEA BAPTIST HOME		DARLINGTON	DARLINGTON	NPA	52	52	65	16,113
N	PRESBYTERIAN HOME SUMMERVILLE	5	DORCHESTER	SUMMERVILLE	NPA	0	0		
N	PRESBYTERIAN HOME FLORENCE	6	FLORENCE	FLORENCE	NPA	44	26	20	11,561
N	METHODIST MANOR HEALTHCARE CTR		FLORENCE	FLORENCE	NPA	32	32	15	9,870
N	LAKES AT LITCHFIELD SKILLED NSG CTR		GEORGETOWN	PAWLEYS ISLAND	PROP	7	7	46	1,753
N	ROLLING GREEN VILLAGE HC FACILITY		GREENVILLE	GREENVILLE	NPA	34	34	73	9,346
N	LINVILLE COURTS CASCADES VERDAE	7	GREENVILLE	GREENVILLE	PROP	22	22		
N	ARBORETUM WOODLANDS AT FURMAN	8	GREENVILLE	GREENVILLE	PROP	13	13		
N	PRESBYTERIAN HOME OF SC CLINTON	9	LAURENS	CLINTON	NPA	48	48	39	21,753
N	MARTHA FRANK BAPTIST HOME		LAURENS	LAURENS	NPA	7	7	11	663
N	SC EPISCOPAL HOME STILL HOPES		LEXINGTON	W COLUMBIA	NPA	42	42	18	12,430
N	LAUREL CREST RETIREMENT CENTER		LEXINGTON	W COLUMBIA	NPA	12	12	7	3,790
N	PRESBYTERIAN HOME OF COLUMBIA	10	LEXINGTON	W COLUMBIA	NPA	44	0	50	14,427
N	CLEMSON AREA RETIREMENT CENTER		PICKENS	CLEMSON	PROP	22	22	20	5,381
N	PRESBYTERIAN HOME OF SC - FOOTHILLS		PICKENS	EASLEY	NPA	18	18	18	6,570
YZN	CM TUCKER JR NURS CTR-FEWELL/STONE		RICHLAND	COLUMBIA	ST	252	252	69	77,337
YZN	CM TUCKER JR NURS CTR-RODDEY		RICHLAND	COLUMBIA	ST	308	308	36	67,273
N	WILDEWOOD DOWNS NSG & REHAB	11	RICHLAND	COLUMBIA	PROP	8	8		
N	WJB DORN VETERANS NURSING		RICHLAND	COLUMBIA	FED	62	150		
N	SKYLYN HEALTH CENTER		SPARTANBURG	SPARTANBURG	PROP	11	11	13	910
N	SUMMIT HILLS NURSING CENTER	12	SPARTANBURG	SPARTANBURG	PROP	6	6	4	182
N	COVENANT PLACE NURS CTR		SUMTER	SUMTER	NPA	44	44	25	1,338
	TOTAL					**1,579**	**1,592**	**927**	**420,787**
	INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED:								
Z	DR DON LESTER PEOPLES COMM RES		ABBEVILLE	WARE SHOALS	ST	8	8		
Z	WARE SHOALS HAB CTR I		ABBEVILLE	WARE SHOALS	ST	8	8		
	ABBEVILLE COUNTY		TOTAL			16	16		
Z	DUPONT I HABILITATION CTR		AIKEN	AIKEN	ST	8	8		
Z	DUPONT II HABILITATION CTR		AIKEN	AIKEN	ST	8	8		
Z	LAURENS STREET ICF/MR		AIKEN	AIKEN	ST	8	8		
Z	LINDEN STREET ICR/MR		AIKEN	AIKEN	ST	8	8		
Z	RUDNICK HABILITATION CTR		AIKEN	AIKEN	ST	8	8		
Z	SANDERS HABILITATION CTR		AIKEN	AIKEN	ST	8	8		
	AIKEN COUNTY		TOTAL			48	48		
Z	ACADEMY STREET COMMUNITY RES		BARNWELL	WILLISTON	ST	8	8		
Z	BLACK'S DRIVE COMMUNITY RES		BARNWELL	WILLISTON	ST	8	8		
Z	HARLEY ROAD COMMUNITY RES		BARNWELL	WILLISTON	ST	8	8		
Z	LEMON PARK COMMUNITY RES		BARNWELL	BARNWELL	ST	8	8		
	BARNWELL COUNTY		TOTAL			32	32		
Z	CONIFER I COMMUNITY RESIDENCE		BERKELEY	MONCKS CORNER	ST	8	8		
Z	CONIFER II COMMUNITY RESIDENCE		BERKELEY	MONCKS CORNER	ST	8	8		
	BERKELEY COUNTY		TOTAL			16	16		
Z	FLORENCE GRESSETTE RESIDENCE		CALHOUN	ST MATTHEWS	ST	8	8		
Z	WYLIE-BRUNSON RESIDENCE		CALHOUN	ST MATTHEWS	ST	8	8		
	CALHOUN COUNTY		TOTAL			16	16		

REGION: STATEWIDE **INPATIENT INVENTORY** **FISCAL YEAR 2008**

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS
Z	DILLS BLUFF COMMUNITY RESIDENCE		CHARLESTON	CHARLESTON	ST	8	8		
	CHARLESTON COUNTY		TOTAL			8	8		
Z	J. CLAUDE FORT COMMUNITY RES #1		CHEROKEE	GAFFNEY	ST	8	8		
Z	J. CLAUDE FORT COMMUNITY RES #2		CHEROKEE	GAFFNEY	ST	8	8		
	CHEROKEE COUNTY		TOTAL			16	16		
Z	CHARLES M. INGRAM, SR COMM RES		CHESTERFIELD	CHERAW	ST	8	8		
Z	CHESTERFIELD COMMUNITY RES		CHESTERFIELD	CHESTERFIELD	ST	8	8		
	CHESTERFIELD COUNTY		TOTAL			16	16		
Z	JOSIE DRIVE COMMUNITY RESIDENCE		COLLETON	WALTERBORO	ST	8	8		
Z	FOREST CIRCLE COMMUNITY RES		COLLETON	WALTERBORO	ST	8	8		
	COLLETON COUNTY		TOTAL			16	16		
Z	JOHN A REAGAN COMMUNITY RES		DARLINGTON	HARTSVILLE	ST	8	8		
Z	THAD E SALEEBY DEVELOPMENT CTR		DARLINGTON	HARTSVILLE	ST	96	96		
Z	WILLIAM W BOWEN RESIDENCE		DARLINGTON	HARTSVILLE	ST	8	8		
	DARLINGTON COUNTY		TOTAL			112	112		
Z	COASTAL CTR -HIGHLANDS & HILLSIDE		DORCHESTER	SUMMERVILLE	ST	192	192		
Z	COASTAL CENTER- HIGHLANDS 510		DORCHESTER	SUMMERVILLE	ST	18	18		
Z	PARSONS I GROUP HOME		DORCHESTER	SUMMERVILLE	ST	8	8		
Z	PARSONS II GROUP HOME		DORCHESTER	SUMMERVILLE	ST	8	8		
	DORCHESTER COUNTY		TOTAL			226	226		
Z	EDGEFIELD COMMUNITY RESIDENCE		EDGEFIELD	EDGEFIELD	ST	8	8		
	EDGEFIELD COUNTY		TOTAL			8	8		
Z	THE CEDARS		FLORENCE	PAMPLICO	ST	8	8		
Z	FLORENCE COMMUNITY RESIDENCE		FLORENCE	FLORENCE	ST	8	8		
Z	JOHNSONVILLE HAMPTON PLACE COM		FLORENCE	JOHNSONVILLE	ST	8	8		
Z	MAGNOLIA PLACE		FLORENCE	OLANTA	ST	8	8		
Z	MULBERRY PARK, UNITS 301-306		FLORENCE	FLORENCE	ST	85	85		
Z	THE OAKS		FLORENCE	TIMMONSVILLE	ST	8	8		
Z	PECAN LANE, BUILDINGS 201-205		FLORENCE	FLORENCE	ST	120	120		
	FLORENCE COUNTY		TOTAL			245	245		
Z	JESSAMINE COMMUNITY RESIDENCE		GEORGETOWN	GEORGETOWN	ST	8	8		
Z	MARYVILLE COMMUNITY RESIDENCE		GEORGETOWN	GEORGETOWN	ST	8	8		
	GEORGETOWN COUNTY					16	16		
Z	CIVITAN COMMUNITY RESIDENCE		GREENVILLE	GREENVILLE	ST	8	8		
Z	FOUNTAIN INN COMMUNITY RESIDENCE		GREENVILLE	FOUNTAIN INN	ST	12	12		
Z	HUGHES STREET COMMUNITY RES		GREENVILLE	FOUNTAIN INN	ST	8	8		
Z	MARIAN PARKINS COMMUNITY RES I		GREENVILLE	GREENVILLE	ST	8	8		
Z	MARIAN PARKINS COMMUNITY RES II		GREENVILLE	GREENVILLE	ST	8	8		
Z	RIDGE ROAD RESIDENCE		GREENVILLE	GREENVILLE	ST	12	12		
Z	TRAVELERS REST COMMUNITY RES		GREENVILLE	TRAVELERS REST	ST	8	8		
	GREENVILLE COUNTY		TOTAL			64	64		

REGION: STATEWIDE **INPATIENT INVENTORY** **FISCAL YEAR 2008**

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS
Z	HENRY & FREIDA BONDS HAB CTR		GREENWOOD	GREENWOOD	ST	8	8		
Z	MARION P CARNELL HAB CTR		GREENWOOD	WARE SHOALS	ST	8	8		
Z	J. FELTON BURTON COMMUNITY RES		GREENWOOD	GREENWOOD	ST	8	8		
	GREENWOOD COUNTY		TOTAL			24	24		
Z	HORRY CO LADIES COMMUNITY RES		HORRY	CONWAY	ST	8	8		
Z	THE LOIS EARGLE HOME		HORRY	CONWAY	ST	8	8		
	HORRY COUNTY		TOTAL			16	16		
Z	CAMDEN I GROUP HOME		KERSHAW	CAMDEN	ST	8	8		
Z	CAMDEN II GROUP HOME		KERSHAW	CAMDEN	ST	8	8		
	KERSHAW COUNTY		TOTAL			16	16		
Z	NANCY J MCCONNELL COMMUNITY RES		LANCASTER	LANCASTER	ST	8	8		
Z	TOM MANGUM COMMUNITY RESIDENCE		LANCASTER	LANCASTER	ST	8	8		
	LANCASTER COUNTY		TOTAL			16	16		
Z	CLINTON MANOR COMMUNITY RES		LAURENS	CLINTON	ST	8	8		
Z	DAVIDSON STREET COMMUNITY RES		LAURENS	CLINTON	ST	8	8		
Z	MILL STREET COMMUNITY RESIDENCE		LAURENS	CLINTON	ST	8	8		
Z	SOUTH HARPER ST HABILITATION CTR		LAURENS	CLINTON	ST	8	8		
Z	SULLIVAN STREET COMMUNITY RES		LAURENS	LAURENS	ST	8	8		
Z	OAK GROVE COMMUNITY RESIDENCE		LAURENS	LAURENS	ST	8	8		
YZ	WHITTEN CTR CTL SQ 201,204,205,207,209		LAURENS	CLINTON	ST	143	143		
Z	WHITTEN CENTER CAMPUS AREA 101-110		LAURENS	CLINTON	ST	152	152		
Z	WHITTEN CENTER SUBER UNITS 301-303		LAURENS	CLINTON	ST	68	68		
	LAURENS COUNTY		TOTAL			411	411		
Z	MCLEOD I GROUP HOME		LEE	BISHOPVILLE	ST	8	8		
Z	MCLEOD II GROUP HOME		LEE	BISHOPVILLE	ST	8	8		
	LEE COUNTY		TOTAL			16	16		
Z	BRUTON SMITH ROAD GROUP HOME		LEXINGTON	LEXINGTON	ST	8	8		
Z	BATESBURG GROUP HOME		LEXINGTON	BATESBURG	ST	8	8		
Z	HENDRIX STREET GROUP HOME		LEXINGTON	LEXINGTON	ST	8	8		
Z	NAZARETH ROAD COMMUNITY RES		LEXINGTON	LEXINGTON	ST	8	8		
Z	WIRE ROAD COMMUNITY RESIDENCE I		LEXINGTON	GILBERT	ST	8	8		
Z	WIRE ROAD COMMUNITY RESIDENCE II		LEXINGTON	GILBERT	ST	8	8		
	LEXINGTON COUNTY		TOTAL			48	48		
Z	JENNINGS MCABEE HABILITATION CTR		MCCORMICK	MCCORMICK	ST	8	8		
	MCCORMICK COUNTY		TOTAL			8	8		
Z	H.A. MCCULLOUGH COMMUNITY RES		NEWBERRY	NEWBERRY	ST	12	12		
	NEWBERRY COUNTY		TOTAL			12	12		
Z	OCONEE COMMUNITY RESIDENCE I		OCONEE	SENECA	ST	8	8		
	OCONEE COUNTY		TOTAL			8	8		
Z	NANCE COMMUNITY RESIDENCE		ORANGEBURG	ORANGEBURG	ST	8	8		
Z	KINGS COMMUNITY RESIDENCE		ORANGEBURG	ORANGEBURG	ST	8	8		
Z	SIFLY COMMUNITY RESIDENCE		ORANGEBURG	ORANGEBURG	ST	8	8		
Z	WANNAMAKER ST COMMUNITY RES		ORANGEBURG	ORANGEBURG	ST	8	8		
	ORANGEBURG COUNTY		TOTAL			32	32		

REGION: STATEWIDE **INPATIENT INVENTORY** **FISCAL YEAR 2008**

ACC	NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS
Z	ARCHIE DRIVE GROUP HOME		RICHLAND	COLUMBIA	ST	8	8		
Z	CARTER STREET GROUP HOME		RICHLAND	COLUMBIA	ST	8	8		
Z	FIRST MIDLANDS ICF-MR		RICHLAND	COLUMBIA	ST	344	344		
Z	HORRELL HILL COMMUNITY RESIDENCE		RICHLAND	HOPKINS	ST	8	8		
Z	IDA I COMMUNITY RESIDENCE		RICHLAND	COLUMBIA	ST	8	8		
Z	IDA II COMMUNITY RESIDENCE		RICHLAND	COLUMBIA	ST	8	8		
Z	KENSINGTON I GROUP HOME		RICHLAND	COLUMBIA	ST	8	8		
Z	KENSINGTON II GROUP HOME		RICHLAND	COLUMBIA	ST	8	8		
Z	NORTH PINES COMMUNITY RESIDENCE		RICHLAND	COLUMBIA	ST	8	8		
Z	RABBIT RUN COMMUNITY RESIDENCE		RICHLAND	HOPKINS	ST	8	8		
Z	WOODLAWN GROUP HOME		RICHLAND	COLUMBIA	ST	8	8		
	RICHLAND COUNTY		TOTAL			424	424		
Z	BENCHMARK HOMES-SPARTANBURG		SPARTANBURG	SPARTANBURG	ST	12	12		
Z	BENCHMARK HOMES-COWPENS		SPARTANBURG	COWPENS	ST	12	12		
Z	LANDRUM COMMUNITY RESIDENCE I		SPARTANBURG	LANDRUM	ST	8	8		
Z	LANDRUM COMMUNITY RESIDENCE II		SPARTANBURG	LANDRUM	ST	8	8		
	SPARTANBURG COUNTY		TOTAL			40	40		
Z	ATKINSON EAST COMMUNITY RESIDENCE		SUMTER	SUMTER	ST	9	9		
Z	ATKINSON WEST COMMUNITY RESIDENCE		SUMTER	SUMTER	ST	9	9		
Z	THOMAS DRIVE COMMUNITY RESIDENCE		SUMTER	SUMTER	ST	8	8		
	SUMTER COUNTY		TOTAL			26	26		
Z	WEST MAIN STREET COMMUNITY RES		UNION	UNION	ST	8	8		
	UNION COUNTY		TOTAL			8	8		
	TOTAL					**1,960**	**1,960**		

FOOTNOTES 2010-2011 PLAN

STATEWIDE

CON	-	Certificate of Need	NPA	-	Non Profit
UC	-	Under Construction	ST	-	State
X	-	Accredited	CO	-	County
Y	-	Medicare	PROP	-	Proprietary
Z	-	Medicaid	N	-	Nursing Home
APP	-	Approved	SW	-	Statewide Facility

1. De-licensed 2 general beds for a total of 196 on 3/25/08 (E-07-65).
2. E-08-78 granted 8/8/08 to return the 178 psychiatric beds on loan to Just Care to G. Werber Bryan for a total of 466 psychiatric beds at GWB. License decreased by 24 beds to 442 beds 5/28/09. Added 50 psych beds 10/1/09 when Crafts Farrow Forensic Building closed, for a total of 492 beds.
3. Initially licensed for 50 psychiatric/forensic care beds 11/5/08. De-licensed 10/1/09 and the 50 beds transferred to G. Werber Bryan.
4. License increased from 140 to 144 beds 1/2/08.
5. CON issued 2/14/08 to convert the 87 institutional nursing home beds to 87 general nursing home beds that do not participate in the Medicaid program, SC-08-08. License classification changed 2/14/08.
6. Exemption issued 4/16/10 for the permanent de-licensure of 18 beds, for a total of 26 licensed nursing home beds.
7. CON issued 9/14/07 for a Continuing Care Retirement Community with 44 institutional nursing home beds, SC-07-41. Licensed for 22 beds 4/21/09; licensed for 44 beds 4/23/09. CON issued 5/12/09 to convert 22 of the beds from institutional beds to nursing home beds not participating in the Medicaid program. The licensed was amended 5/12/09 to reflect the change to 22 institutional and 22 nursing home beds not participating in the Medicaid program.
8. CON approved 6/13/06 to construct a Continuing Care Retirement Community with 13 institutional nursing home beds and 17 nursing home beds that do not participate in the Medicaid program. Licensed 6/2/09.
9. CON issued 3/12/09 to change the licensure of 18 institutional beds to community beds not participating in the Medicaid program, SC-09-14. Licensed amended 4/23/09.
10. CON issued 2/14/08 to convert the 44 institutional nursing home beds to 44 general nursing home beds that do not participate in the Medicaid program, SC-08-09. License classification changed 2/14/08.
11. CON issued 9/11/08 for the addition of 8 institutional beds and 40 general nursing home beds for a total of 80 beds (8 institutional and 72 general), SC-08-35. Licensed 9/10/09.
12. CON issued 3/14/07 for a Continuing Care Retirement Community with 6 institutional nursing home beds and 27 nursing home beds that do not participate in the Medicaid program. Licensed 3/18/08.

DETERMINATION OF REGION NEED AND NARRATIVE

REGION: I FISCAL YEAR: 2008

1. Unusual Characteristics: There are no unusual characteristics such as military bases with associated dependents, nor barriers to transportation in this region.

2. General Hospitals: W.J. Barge Hospital is a privately owned Educational Institutional Infirmary.

3. Nursing Homes: There is a need for additional nursing home beds in this area.

4. Psychiatric Facilities: The need is determined by psychiatric service area. See Chapter II for discussion and calculation of needs.

5. Alcohol and Drug Abuse Facilities: These needs were developed in conjunction with the S.C. Department of Alcohol and Other Drug Abuse Services. Because of the high use rate at the William J. McCord Facility in Orangeburg and the lack of other adolescent services, it may be necessary for an additional adolescent state facility to be constructed in this Region to increase geographic accessibility to services. Any such proposal must have DAODAS support. See Chapter II for discussion and calculations.

6. Rehabilitation Facilities: The need is determined by rehabilitation service area. See Chapter II for discussion and calculation of needs.

REGION: I **INPATIENT INVENTORY** **FISCAL YEAR 2008**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
HOSPITALS:										
ANMED HEALTH MEDICAL CENTER		ANDERSON	ANDERSON	NPA	423	423	13,940	78,082	423	50.4%
ANMED HEALTH WOMEN'S & CHILDREN'S HOSPITAL		ANDERSON	ANDERSON	NPA	72	72	3,539	8,880	72	33.7%
ANDERSON COUNTY		TOTAL			495	495	17,479	86,962	495	48.0%
UPSTATE CAROLINA MEDICAL CENTER		CHEROKEE	GAFFNEY	PROP	125	125	3,914	15,522	125	33.9%
CHEROKEE COUNTY		TOTAL			125	125	3,914	15,522	125	33.9%
GREENVILLE MEMORIAL MEDICAL CENTER	1	GREENVILLE	GREENVILLE	NPA	746	746	39,541	182,305	746	66.8%
GREER MEMORIAL HOSPITAL/ALLEN BENNETT	1	GREENVILLE	GREER	NPA	82	82	3,133	12,125	68.9	48.1%
HILLCREST MEMORIAL HOSPITAL		GREENVILLE	SIMPSONVILLE	NPA	43	43	1,867	7,966	43	50.6%
PATEWOOD MEMORIAL HOSPITAL		GREENVILLE	GREENVILLE	NPA	72	72	1,207	2,823	72	10.7%
SAINT FRANCIS - DOWNTOWN	2	GREENVILLE	GREENVILLE	NPA	226	224	11,739	64,299	226	77.7%
SAINT FRANCIS MILLENNIUM	2	GREENVILLE	GREENVILLE	NPA		52				
SAINT FRANCIS - EASTSIDE		GREENVILLE	GREENVILLE	NPA	93	93	6,721	19,225	93	56.5%
GREENVILLE COUNTY		TOTAL			1,262	1,312	64,208	288,743	1,249	63.2%
OCONEE MEDICAL CENTER	3	OCONEE	SENECA	NPA	169	169	6,241	26,231	160	44.8%
OCONEE COUNTY					169	169	6,241	26,231	160	44.8%
BAPTIST EASLEY HOSPITAL	4	PICKENS	EASLEY	NPA	109	109	5,130	20,524	109	51.4%
CANNON MEMORIAL HOSPITAL		PICKENS	PICKENS	NPA	42	42	985	3,771	55	18.7%
PICKENS COUNTY		TOTAL			42	42	985	3,771	55	18.7%
MARY BLACK MEMORIAL HOSPITAL		SPARTANBURG	SPARTANBURG	PROP	176	176	6,929	28,537	176	44.3%
SPARTANBURG REGIONAL MEDICAL CENTER	5	SPARTANBURG	SPARTANBURG	CO	484	484	26,276	138,364	522.2	72.4%
VILLAGE HOSPITAL	5	SPARTANBURG	GREER	CO	48	48				
SPARTANBURG COUNTY		TOTAL			708	708	33,205	166,901	698.2	65.3%
WALLACE THOMSON HOSPITAL		UNION	UNION	DIST	143	143	2,745	11,055	143	21.1%
UNION COUNTY		TOTAL			143	143	2,745	11,055	143	21.1%
TOTAL					2,944	2,994	128,777	599,185	2,925	56.0%
LONG TERM ACUTE HOSPITALS:										
NORTH GREENVILLE HOSP LONG TERM ACUTE		GREENVILLE	TRAVELERS REST	NPA	45	45	324	9,547	45	58.0%
REGENCY HOSPITAL OF GREENVILLE		GREENVILLE	GREENVILLE	NPA	32	32	337	8,694	32	74.2%
SPARTANBURG HOSPITAL FOR RESTORATIVE CARE		SPARTANBURG	SPARTANBURG	CO	97	97	406	11,803	97	33.2%
TOTAL					129	129	1,067	30,044	174	47.2%
MENTAL FACILITIES:										
ANMED HEALTH MEDICAL CENTER		ANDERSON	ANDERSON	NPA	38	38	972	6,009	38	43.2%
ANDERSON COUNTY		TOTAL			38	38	972	6,009	38	43.2%
CAROLINA CENTER FOR BEHAVIORAL HEALTH	6	GREENVILLE	GREENVILLE	PROP	84	99	2,249	23,632	76	85.0%
SPRINGBROOK BEHAVIORAL HEALTHCARE	7	GREENVILLE	TRAVELERS REST	PROP	20	37	403	4,291	20	58.6%
GREENVILLE MEMORIAL MEDICAL CENTER	2	GREENVILLE	GREENVILLE	NPA	46	46	1,388	14,238	46	84.6%
GREENVILLE COUNTY		TOTAL			150	182	4,040	42,161	142	81.1%
MARY BLACK MEMORIAL HOSPITAL		SPARTANBURG	SPARTANBURG	PROP	15	15	329	4,385	15	79.9%
SPARTANBURG REGIONAL MEDICAL CENTER		SPARTANBURG	SPARTANBURG	CO	56	56	865	7,291	56	35.6%
SPARTANBURG COUNTY		TOTAL			71	71	1,194	11,676	71	44.9%
TOTAL					259	291	6,206	59,846	251.0	65.1%

REGION: I **INPATIENT INVENTORY** **FISCAL YEAR 2008**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS:										
EXCALIBUR YOUTH SERVICES	8	GREENVILLE	SIMPSONVILLE	PROP	60	60				
MARSHALL I. PICKENS CHILDREN'S PROGRAM		GREENVILLE	GREENVILLE	NPA	22	22	31	7,347	22	91.2%
SPRINGBROOK BEHAVIORAL HEALTHCARE		GREENVILLE	TRAVELERS REST	PROP	68	68	52	22,023	68	88.5%
AVALONIA GROUP HOME	9	PICKENS	PICKENS	PROP	55	55				
TOTAL					205	205	83	29,370	90	89.2%
DRUG AND ALCOHOL INPATIENT TREATMENT:										
(ANMED HEALTH WELLSPRING)	10	ANDERSON	WILLIAMSON	NPA	0	0	673	1,993	27	20.2%
CAROLINA CENTER FOR BEHAVIORAL HEALTH		GREENVILLE	GREENVILLE	PROP	13	13	600	4,852	13	102.0%
TOTAL					13	13	1,273	6,845	40	46.8%
REHABILITATION FACILITIES:										
ANMED HEALTH REHABILITATION HOSPITAL	11	ANDERSON	ANDERSON	PROP	45	45	914	12,821	37	94.7%
ANDERSON COUNTY		TOTAL			45	45	914	12,821	37	94.7%
GREENVILLE MEMORIAL MEDICAL CENTER		GREENVILLE	GREENVILLE	NPA	53	53	680	10,984	53	56.6%
SAINT FRANCIS HOSPITAL - DOWNTOWN		GREENVILLE	GREENVILLE	NPA	19	19	439	5,993	19	86.2%
GREENVILLE COUNTY		TOTAL			72	72	1,119	16,977	72	64.4%
MARY BLACK MEMORIAL HOSPITAL		SPARTANBURG	SPARTANBURG	PROP	18	18	415	5,596	18	84.9%
SPARTANBURG COUNTY		TOTAL			18	18	415	5,596	18	84.9%
TOTAL					135	135	2,448	35,394	127	76.1%
INPATIENT HOSPICE FACILITIES:										
CALLIE & JOHN RAINEY HOSPICE HOUSE		ANDERSON	ANDERSON	NPA	32	32	643	8,265	32	70.6%
MCCALL HOSPICE HOUSE OF GREENVILLE		GREENVILLE	SIMPSONVILLE	NPA	30	30	416	6,004	30	54.7%
OCONEE MEMORIAL HOSPICE FOOTHILLS		OCONEE	SENECA	NPA	15	15	196	2,641	15	48.1%
HOSPICE HOUSE OF CAROLINA FOOTHILLS	12	SPARTANBURG	LANDRUM	NPA	12	12				
SPARTANBURG REG HEALTHCARE HOSPICE		SPARTANBURG	SPARTANBURG	NPA	15	15	636	4,352	15	79.3%
TOTAL					104	104	1,891	21,262	92	63.1%
LONG TERM CARE FACILITIES:										
ANDERSON PLACE		ANDERSON	ANDERSON	PROP	44	44	37	11,609	44	72.1%
BROOKSIDE LIVING CENTER		ANDERSON	ANDERSON	PROP	88	88	349	30,997	88	96.2%
ELLENBURG NURSING CENTER		ANDERSON	ANDERSON	PROP	181	181	253	63,455	181	95.8%
NHC HEALTHCARE ANDERSON		ANDERSON	ANDERSON	PROP	290	290	528	103,986	290	98.0%
RIVERSIDE LIVING CENTER		ANDERSON	ANDERSON	PROP	88	88	271	31,565	88	98.0%
WILLOW CREEK LIVING CENTER		ANDERSON	IVA	PROP	60	60	161	21,208	60	96.6%
ANDERSON COUNTY		TOTAL			751	751	1,599	262,819	751	95.6%
BROOKVIEW HEALTHCARE CENTER		CHEROKEE	GAFFNEY	PROP	132	132	200	46,012	132	95.2%
CHEROKEE COUNTY LONG TERM CARE FACILITY	13	CHEROKEE	GAFFNEY	CO	97	97	142	33,621	97	94.7%
CHEROKEE COUNTY		TOTAL			229	229	342	79,633	229	95.0%
ARBORETUM OF WOODLANDS AT FURMAN	14	GREENVILLE	GREENVILLE	PROP	17	17				
(ARBORETUM OF WOODLANDS AT FURMAN)		GREENVILLE	GREENVILLE	PROP	(13)	(13)				
BRIARWOOD LIVING CENTER		GREENVILLE	SIMPSONVILLE	PROP	42	42	32	13,791	42	89.7%
BRIGHTON GARDENS		GREENVILLE	GREENVILLE	PROP	45	45	206	14,884	45	90.4%
COTTAGES AT BRUSHY CREEK		GREENVILLE	GREENVILLE	NPA	144	144	276	35,623	144	67.6%
FALLS CREEK LIVING CENTER		GREENVILLE	MARIETTA	NPA	44	44	42	15,634	44	97.1%
FOUNTAIN INN NURSING HOME	15	GREENVILLE	FOUNTAIN INN	PROP	60	60	66	15,379	44	95.5%
GREENVILLE LIVING CENTER		GREENVILLE	GREENVILLE	PROP	79	79	67	27,098	79	93.7%
GREENVILLE MEMORIAL MED CTR SUBACUTE	1	GREENVILLE	GREENVILLE	NPA	15	15	299	4,699	15	85.6%
LAUREL BAYE HEALTHCARE OF GREENVILLE		GREENVILLE	GREENVILLE	PROP	132	132	168	45,260	132	93.7%
LINVILLE COURTS AT CASCADES VERDAE	16	GREENVILLE	GREENVILLE	PROP	22	22				
(LINVILLE COURTS AT CASCADES VERDE)		GREENVILLE	GREENVILLE	PROP	(22)	(22)				
MAGNOLIA MANOR - GREENVILLE		GREENVILLE	GREENVILLE	PROP	99	99	65	34,878	99	96.3%
MAGNOLIA PLACE - GREENVILLE		GREENVILLE	GREENVILLE	PROP	120	120	59	42,746	120	97.3%

REGION: I **INPATIENT INVENTORY** **FISCAL YEAR 2008**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
NHC HEALTHCARE GREENVILLE		GREENVILLE	GREER	PROP	176	176	448	62,425	176	96.9%
NHC HEALTHCARE MAULDIN		GREENVILLE	MAULDIN	PROP	180	180	454	62,845	180	95.4%
OAKMONT EAST NURSING CENTER		GREENVILLE	GREENVILLE	PROP	132	132	316	45,937	132	95.1%
OAKMONT WEST NURSING CENTER		GREENVILLE	GREENVILLE	PROP	125	125	340	43,237	124	95.3%
PIEDMONT LIVING CENTER		GREENVILLE	GREER	PROP	132	132	466	30,992	132	64.1%
ROLLING GREEN VILLAGE HEALTH CARE FACILITY		GREENVILLE	GREENVILLE	NPA	10	10	22	2,749	10	75.1%
(ROLLING GREEN VILLAGE HEALTH CARE FACILITY)		GREENVILLE	GREENVILLE	NPA	(34)	(34)				
SUMMIT PLACE LIVING CENTER		GREENVILLE	SIMPSONVILLE	PROP	132	132	237	46,597	132	96.5%
WESTSIDE LIVING CENTER		GREENVILLE	GREENVILLE	PROP	132	132	248	46,697	132	96.7%
GREENVILLE COUNTY		TOTAL			1,838	1,838	3,811	591,471	1,782	90.7%
LILA DOYLE NURSING CARE FACILITY		OCONEE	SENECA	CO	120	120	488	40,787	120	92.9%
SENECA HEALTH AND REHABILITATION CENTER		OCONEE	SENECA	PROP	132	132	226	46,248	132	95.7%
OCONEE COUNTY		TOTAL			252	252	714	87,035	252	94.4%
BLUE RIDGE LIVING CENTER		PICKENS	EASLEY	PROP	66	66	93	23,441	66	97.0%
CLEMSON AREA RETIREMENT CENTER		PICKENS	CLEMSON	PROP	30	30	27	7,337	30	66.8%
(CLEMSON AREA RETIREMENT CENTER)		PICKENS	CLEMSON	PROP	(22)	(22)				
COUNTRYSIDE HEALTHCARE CENTER		PICKENS	EASLEY	PROP	44	44	47	13,918	44	86.4%
EASLEY LIVING CENTER		PICKENS	EASLEY	PROP	103	103	236	36,157	103	95.9%
HERITAGE HEALTHCARE OF PICKENS	17	PICKENS	SIX MILE	PROP	44	44	26	15,806	44	98.1%
LAUREL HILL LIVING CENTER		PICKENS	PICKENS	PROP	80	80	173	28,280	80	96.6%
PRESBYTERIAN HOME - FOOTHILLS	18	PICKENS	EASLEY	PROP	0	26				
(PRESBYTERIAN HOME - FOOTHILLS)		PICKENS	EASLEY	PROP	(18)	(18)				
ROSEMOND LIVING CENTER		PICKENS	PICKENS	PROP	44	44	39	16,721	44	103.8%
PICKENS COUNTY		TOTAL			411	437	641	141,660	411	94.2%
CAMP CARE		SPARTANBURG	INMAN	PROP	88	88	73	31,728	88	98.5%
GOLDEN AGE - INMAN		SPARTANBURG	INMAN	PROP	44	44	45	15,211	44	94.5%
INMAN HEALTHCARE		SPARTANBURG	INMAN	PROP	40	40	49	13,762	40	94.0%
MAGNOLIA MANOR - INMAN		SPARTANBURG	INMAN	PROP	176	176	156	63,499	176	98.6%
MAGNOLIA MANOR - SPARTANBURG	19	SPARTANBURG	SPARTANBURG	PROP	95	95	112	34,006	95	97.8%
MAGNOLIA PLACE - SPARTANBURG		SPARTANBURG	SPARTANBURG	PROP	88	88	168	30,956	88	96.1%
MOUNTAINVIEW NURSING HOME		SPARTANBURG	SPARTANBURG	CO	132	132	47	47,843	132	99.0%
ROSECREST REHABILITATION & HEALTHCARE		SPARTANBURG	INMAN	NPA	75	75	244	22,914	75	83.5%
SKYLYN HEALTH CENTER	19	SPARTANBURG	SPARTANBURG	PROP	33	33	41	2,732	33	22.6%
(SKYLYN HEALTH CENTER)		SPARTANBURG	SPARTANBURG	PROP	(11)	(11)				
SPARTANBURG HOSP RESTORATIVE CARE SNF		SPARTANBURG	SPARTANBURG	CO	25	25	433	5,171	25	56.5%
SUMMIT HILLS NURSING CENTER	20	SPARTANBURG	SPARTANBURG	PROP	27	27	8	818	27	8.3%
(SUMMIT HILLS NURSING CENTER)		SPARTANBURG	SPARTANBURG	PROP	(6)	(6)				
VALLEY FALLS TERRACE		SPARTANBURG	SPARTANBURG	PROP	88	88	47	30,940	88	96.1%
WHITE OAK MANOR - SPARTANBURG		SPARTANBURG	SPARTANBURG	PROP	192	192	200	68,465	192	97.4%
WHITE OAK ESTATES		SPARTANBURG	SPARTANBURG	PROP	88	88	126	31,684	88	98.4%
WOODRUFF MANOR		SPARTANBURG	WOODRUFF	PROP	88	88	43	6,368	88	19.8%
SPARTANBURG COUNTY		TOTAL			1,279	1,279	1,792	406,097	1,279	86.8%
ELLEN SAGAR NURSING HOME	19	UNION	UNION	CO	113	113	133	40,788	113	98.6%
OAKMONT OF UNION		UNION	UNION	PROP	88	88	280	30,152	88	93.6%
UNION COUNTY		TOTAL			201	201	413	70,940	201	96.4%
TOTAL					**4,961**	**4,987**	**9,312**	**1,639,655**	**4,905**	**91.3%**

FOOTNOTES 2010-2011 PLAN

REGION I

CON	-	Certificate of Need	NPA	-	Non Profit
UC	-	Under Construction	ST	-	State
X	-	Accredited	CO	-	County
Y	-	Medicare	PROP	-	Proprietary
Z	-	Medicaid	N	-	Nursing Home
APP	-	Approved	SW	-	Statewide Facility

1. CON issued 7/18/05 to construct a replacement hospital for ABM (Greer Memorial Hospital) to include the existing 58 beds and the conversion of the 10 nursing home beds to acute care for a total of 68 general beds, SC-05-49. The CON was amended 1/5/06 to withdraw the conversion of the 10 nursing home beds. CON issued 8/14/06 to add 14 beds to Greer Memorial for a total of 72, SC-06-48. CON issued 6/22/07 to convert the 10 nursing home beds at ABM to general acute for a total of 68 acute beds, with the beds to be relocated to Greer Memorial when it opens, for a total of 82 acute beds, SC-07-28. The last patient left the ABM Subacute Unit on 9/28/06, but the 10 nursing home beds were not de-licensed and converted to general acute beds until 11/20/07, for a total of 68 currently licensed acute beds. Greer Memorial was licensed for 82 beds and Allen Bennett closed 8/5/08.
2. CON issued 6/12/09 to construct a new 52 bed hospital (St. Francis millennium) through the transfer of the 50 bed need generated by St. Francis Downtown and the transfer of 2 beds from St. Francis Downtown, for a total of 224 beds at St. Francis Downtown, SC-09-28.
3. CON issued for a 9 bed addition 9/14/06, SC-06-55. Licensed for 169 beds, 4/15/10. Name changed from Oconee Memorial Hospital.
4. Formerly Palmetto Baptist Medical Center Easley.
5. CON issued 9/9/05 to construct Village Health Centre, a new 48-bed hospital, by transferring 48 acute care beds from Spartanburg Regional Medical Center, SC-05-63. Village Hospital licensed for 48 beds and the number of licensed beds at SRMC was reduced from 532 to 484 on 9/23/08.
6. CON issued 8/10/09 to add 23 psych beds for a total of 99 psych and 13 substance abuse beds, SC-09-37. Licensed 8 additional psych beds for a total of 84, 2/16/10.
7. CON issued 8/10/09 to add 17 psych beds for a total of 37 psych and 68 RTF beds, SC-09-38.
8. Facility converted from a High Management Group Home, licensed for 42 Residential Treatment Facility 12/31/08. CON issued 3/26/09 to add 18 beds for a total of 60, SC-09-15. Licensed for 60 beds 6/26/09.
9. Facility converted from a High Maintenance Group Home to a 55 bed Residential Treatment Facility on 9/18/08.
10. De-licensed 11/08.
11. CON to convert 3 nursing home beds to rehab beds, for a total of 40 rehab beds 5/14/09, SC-09-25. CON issued for 5 additional rehab beds, for a total of 45, 7/8/09, SC-09-35. Licensed for 40 rehab beds 7/1/09; licensed for 45 beds 4/22/10.
12. CON issued 7/28/06 for a 12-bed inpatient hospice facility, SC-06-44. Licensed 3/31/09.
13. CON issued 11/12/08 to add 14 additional nursing home beds for a total of 111 beds, SC-08-49. Licensed for 111 beds 5/5/09.
14. CON issued 7/3/06 to construct a Continuing Care Retirement Community with 13 institutional nursing home beds and 17 nursing home beds which do not participate in Medicaid, SC-06-34. Licensed 6/2/09.

15. CON issued 7/29/05 to construct a replacement facility and add 16 beds that do not participate in the Medicaid Program, for a total of 60 nursing home beds, SC-05-53. CON voided and then replaced with CON SC-08-04, 1/24/08. Licensed for 60 beds 3/24/09.
16. CON issued 9/14/07 for a Continuing Care Retirement Community with 44 institutional nursing home beds, SC-07-41, called the Skilled Nursing Center at Cascades Verde. Licensed for 22 beds 4/21/09; licensed for 44 beds 4/23/09. CON issued 5/12/09 to convert 22 of the beds from institutional beds to nursing home beds not participating in the Medicaid program. The licensed was amended 5/12/09 to reflect the change to 22 institutional and 22 nursing home beds not participating in the Medicaid program. Name changed 8/8/09.
17. Formerly Harvey's Nursing Home.
18. CON issued 1/14/10 to construct 26 nursing home beds for a total of 44, with 18 restricted to residents of the retirement community, SC-10-04.
19. 2007 Data.
20. CON issued 3/14/07 for a Continuing Care Retirement Community with 6 institutional nursing home beds and 27 nursing home beds that do not participate in the Medicaid program, SC-07-09. Facility licensed 3/18/08.

INVENTORY OF EMERGENCY FACILITIES 2008 UTILIZATION

CATEGORY	NAME OF FACILITY	COUNTY	CITY	2008 ER VISITS
REGION I:	EMERGENCY FACILITIES			
II	ANMED HEALTH MEDICAL CENTER	ANDERSON	ANDERSON	80,124
III	UPSTATE CAROLINA MEDICAL CENTER	CHEROKEE	GAFFNEY	28,940
II	GREENVILLE MEMORIAL HOSPITAL	GREENVILLE	GREENVILLE	85,135
I	GREER MEMORIAL/ALLEN BENNETT	GREENVILLE	GREER	28,956
II	HILLCREST HOSPITAL	GREENVILLE	SIMPSONVILLE	26,541
III	NORTH GREENVILLE LTACH	GREENVILLE	TRAVELERS REST	18,808
II	SAINT FRANCIS - DOWNTOWN	GREENVILLE	GREENVILLE	40,395
II	SAINT FRANCIS - EASTSIDE	GREENVILLE	GREENVILLE	31,772
III	OCONEE MEMORIAL HOSPITAL	OCONEE	SENECA	39,467
III	PALMETTO BAPTIST MED CTR-EASLEY	PICKENS	EASLEY	41,102
III	CANNON MEMORIAL HOSPITAL	PICKENS	PICKENS	17,637
III	MARY BLACK MEMORIAL HOSPITAL	SPARTANBURG	SPARTANBURG	25,747
I	SPARTANBURG REGIONAL MED CTR	SPARTANBURG	SPARTANBURG	108,860
III	WALLACE THOMSON HOSPITAL	UNION	UNION	17,155
			TOTAL	590,639

REGION I:	TRAUMA CENTERS		
II	ANMED HEALTH MEDICAL CENTER	ANDERSON	ANDERSON
I	GREENVILLE MEMORIAL HOSPITAL	GREENVILLE	GREENVILLE
III	GREER MEMORIAL/ALLEN BENNETT	GREENVILLE	GREER
I	SPARTANBURG REGIONAL MED CTR	SPARTANBURG	SPARTANBURG

DETERMINATION OF REGION NEED AND NARRATIVE

REGION: II FISCAL YEAR: 2008

1. Unusual Characteristics: This region has a military base at Fort Jackson with a military hospital to provide health care services for the active duty and dependents residing in this region. A 457 bed Veterans Administration Hospital and 120 bed Veterans Nursing Home is located in Columbia. There are no barriers to transportation. Most State owned psychiatric facilities and the largest substance abuse treatment facility are located in this region.

2. General Hospitals: Utilization of Federal facilities is included in the inventory for information only. All facilities are conforming. After a review of patient origin information, the population used to calculate Richland County hospital bed need is 91.7% of the Richland County population plus 42.5% of the population of Lexington County. For Lexington County, 57.5% of the Lexington County population plus 8.3% of the Richland County population is used. A separate bed need is indicated for each county.

3. Nursing Homes: There is a need for additional nursing home beds in this region.

4. Psychiatric Facilities: The need is determined by psychiatric service area. See Chapter II for discussion and calculation of needs.

5. Alcohol and Drug Abuse Facilities: These needs were developed in conjunction with the S.C. Department of Alcohol and Other Drug Abuse Services. See Chapter II for discussion and calculations.

6. Rehabilitation Facilities: The need is determined by rehabilitation service area. See Chapter II for discussion and calculation of needs.

REGION: II **INPATIENT INVENTORY** **FISCAL YEAR 2008**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
HOSPITALS:										
ABBEVILLE AREA MEDICAL CENTER		ABBEVILLE	ABBEVILLE	CO	25	25	917	3,323	25	36.3%
ABBEVILLE COUNTY		TOTAL			25	25	917	3,323	25	36.3%
CHESTER REGIONAL MEDICAL CENTER		CHESTER	CHESTER	DIST	82	82	2,068	7,313	82	24.4%
CHESTER COUNTY		TOTAL			82	82	2,068	7,313	82	24.4%
EDGEFIELD COUNTY HOSPITAL		EDGEFIELD	EDGEFIELD	CO	25	25	744	1,975	25	21.6%
EDGEFIELD COUNTY		TOTAL			25	25	744	1,975	25	21.6%
FAIRFIELD MEMORIAL HOSPITAL		FAIRFIELD	WINNSBORO	NPA	25	25	744	3,158	25	34.5%
FAIRFIELD COUNTY		TOTAL			25	25	744	3,158	25	34.5%
SELF REGIONAL HEALTHCARE	1	GREENWOOD	GREENWOOD	NPA	354	354	13,109	53,756	340.1	43.2%
GREENWOOD COUNTY		TOTAL			354	354	13,109	53,756	340.1	43.2%
KERSHAW HEALTH		KERSHAW	CAMDEN	CO	121	121	6,185	27,361	121	61.8%
KERSHAW COUNTY		TOTAL			121	121	6,185	27,361	121	61.8%
SPRINGS MEMORIAL HOSPITAL	2	LANCASTER	LANCASTER	NPA	168	217	7,046	30,911	168	50.3%
LANCASTER COUNTY		TOTAL			168	217	7,046	30,911	168	50.3%
LAURENS COUNTY HOSPITAL		LAURENS	LAURENS	DIST	76	76	2,964	12,429	76	44.7%
LAURENS COUNTY		TOTAL			76	76	2,964	12,429	76	44.7%
LEXINGTON MEDICAL CENTER	3	LEXINGTON	WEST COLUMBIA	CO	384	414	20,279	97,753	361.4	73.9%
LEXINGTON COUNTY		TOTAL			384	414	20,279	97,753	361.4	73.9%
NEWBERRY COUNTY MEMORIAL HOSPITAL		NEWBERRY	NEWBERRY	CO	90	90	2,679	10,777	90	32.7%
NEWBERRY COUNTY		TOTAL			90	90	2,679	10,777	90	32.7%
PALMETTO HEALTH BAPTIST	4	RICHLAND	COLUMBIA	NPA	363	287	15,462	68,789	363	51.8%
PALMETTO HEALTH PARKRIDGE	4	RICHLAND	COLUMBIA	NPA		76				
PALMETTO HEALTH RICHLAND		RICHLAND	COLUMBIA	NPA	579	579	34,380	159,860	579	75.4%
PROVIDENCE HOSPITAL		RICHLAND	COLUMBIA	PROP	258	258	10,658	55,306	258	58.6%
PROVIDENCE HOSPITAL NORTHEAST	5	RICHLAND	COLUMBIA	PROP	56	84	3,026	10,260	46	60.9%
(MONCRIEF ARMY HOSPITAL)	6	RICHLAND	COLUMBIA	FED		(63)				
(W J B DORN VA HOSPITAL)	6	RICHLAND	COLUMBIA	FED		(400)				
RICHLAND COUNTY		TOTAL			1,256	1,284	63,526	294,215	1,246	64.5%
FORT MILL MEDICAL CENTER	7	YORK	FORT MILL	PROP		100				
PIEDMONT MEDICAL CENTER	7	YORK	ROCK HILL	PROP	268	232	13,526	61,429	268	62.6%
YORK COUNTY		TOTAL			268	332	13,526	61,429	268	62.6%
TOTAL					2,874	3,045	133,787	604,400	2,828	58.4%
LONG TERM ACUTE HOSPITALS:										
INTERMEDICAL HOSPITAL OF SOUTH CAROLINA		RICHLAND	COLUMBIA	NPA	35	35	278	8,459	35	66.0%
TOTAL					35	35	278	8,459	35	66.0%
MENTAL FACILITIES:										
SELF REGIONAL HEALTHCARE		GREENWOOD	GREENWOOD	NPA	36	36	618	4,012	36	30.4%
GREENWOOD COUNTY		TOTAL			36	36	618	4,012	36	30.4%
THREE RIVERS BEHAVIORAL HEALTH	8	LEXINGTON	WEST COLUMBIA	PROP	81	81	1,450	16,539	43.5	103.9%
LEXINGTON COUNTY		TOTAL			81	81	1,450	16,539	43.5	103.9%
PALMETTO HEALTH BAPTIST	9	RICHLAND	COLUMBIA	NPA	94	94	1,945	24,020	102	64.3%
PALMETTO HEALTH RICHLAND		RICHLAND	COLUMBIA	CO	60	60	770	6,636	60	30.2%
(MONCRIEF ARMY HOSPITAL)	6	RICHLAND	COLUMBIA	FED		(20)				

REGION: II **INPATIENT INVENTORY** **FISCAL YEAR 2008**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
(W J B DORN VA)	6	RICHLAND	COLUMBIA	FED		(60)				
RICHLAND COUNTY		TOTAL			154	154	2,715	30,656	162	51.7%
PIEDMONT MEDICAL CENTER		YORK	ROCK HILL	PROP	20	20	522	2,897	20	39.6%
YORK COUNTY		TOTAL			20	20	522	2,897	20	39.6%
TOTAL					291	291	5,305	54,104	262	56.5%
RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS:										
THREE RIVERS RES. TREAT. - MIDLANDS		LEXINGTON	WEST COLUMBIA	PROP	59	59	67	20,932	59	96.9%
THREE RIVERS BEHAVIORAL HEALTH RTC		LEXINGTON	WEST COLUMBIA	PROP	20	20	22	6,894	20	94.2%
CAROLINA CHILDREN'S HOME	10	RICHLAND	COLUMBIA	NPA	20	20				
NEW HOPE CAROLINAS	11	YORK	ROCK HILL	PROP	150	150				
YORK PLACE EPISCOPAL HOME		YORK	YORK	PROP	40	40	49	11,044	40	75.4%
TOTAL					289	289	138	38,870	119	89.2%
DRUG AND ALCOHOL INPATIENT TREATMENT:										
SPRINGS MEMORIAL HOSPITAL	2	LANCASTER	LANCASTER	NPA	18	0	7	28	18	0.4%
THREE RIVERS BEHAVIORAL HEALTH	8	LEXINGTON	WEST COLUMBIA	PROP	17	17	399	2,552	22.6	30.9%
PALMETTO HEALTH BAPTIST	9	RICHLAND	COLUMBIA	CO	10	10	0	0	1.9	0.0%
PALMETTO HEALTH RICHLAND		RICHLAND	COLUMBIA	CO	10	10	385	3,442	10	94.0%
SELF REGIONAL HEALTHCARE		GREENWOOD	GREENWOOD	NPA	24	24	0	0	24	0.0%
TOTAL					79	61	791	6,022	76.5	21.5%
REHABILITATION FACILITIES:										
GREENWOOD REGIONAL REHAB HOSPITAL		GREENWOOD	GREENWOOD	NPA	34	34	613	8,415	34	67.6%
GREENWOOD COUNTY		TOTAL			34	34	613	8,415	34	67.6%
HEALTHSOUTH REHAB HOSPITAL COLUMBIA		RICHLAND	COLUMBIA	PROP	96	96	1,502	21,297	96	60.6%
RICHLAND COUNTY		TOTAL			96	96	1,502	21,297	96	60.6%
HEALTHSOUTH REHAB HOSPITAL ROCK HILL	12	YORK	ROCK HILL	PROP	40	46	921	12,977	40	88.6%
YORK COUNTY		TOTAL			40	46	921	12,977	40	88.6%
TOTAL					170	176	3,036	42,689	170	68.6%
INPATIENT HOSPICE FACILITIES:										
HOSPICE HOUSE OF HOSPICECARE PIEDMONT		GREENWOOD	GREENWOOD	NPA	15	15	351	3,183	15	58.0%
HOSPICE OF LAURENS CO INPT HOSPICE HOUSE	13	LAURENS	CLINTON	PROP	12	12	15	122	1.9	17.5%
HEARTLAND HOSPICE HOUSE MIDLANDS		RICHLAND	COLUMBIA	PROP	12	12	141	1,976	12	45.0%
ASCENSION HOUSE		RICHLAND	IRMO	PROP	14	14	418	2,815	14	54.9%
HOSPICE AND COMMUNITY CARE	14	YORK	ROCK HILL	NPA	16	16	194	1,826	16	31.2%
TOTAL					69	69	1,119	9,922	58.9	46.0%
LONG TERM CARE FACILITIES:										
ABBEVILLE NURSING HOME		ABBEVILLE	ABBEVILLE	PROP	94	94	55	32,127	94	93.4%
CARLISLE NURSING CENTER		ABBEVILLE	DUE WEST	NPA	22	22	15	7,179	22	89.2%
ABBEVILLE COUNTY		TOTAL			116	116	70	39,306	116	92.6%
CHESTER NURSING CENTER		CHESTER	CHESTER	CO	100	100	143	34,111	100	93.2%
CHESTER COUNTY		TOTAL			100	100	143	34,111	100	93.2%
TRINITY MISSION EDGEFIELD		EDGEFIELD	EDGEFIELD	PROP	120	120	55	42,163	120	96.0%
EDGEFIELD COUNTY		TOTAL			120	120	55	42,163	120	96.0%
FAIRFIELD HEALTHCARE CENTER		FAIRFIELD	RIDGEWAY	PROP	112	104	67	39,389	112	96.1%
HERITAGE HEALTHCARE OF RIDGEWAY	17	FAIRFIELD	RIDGEWAY	PROP	150	150	158	52,763	150	96.1%
FAIRFIELD COUNTY		TOTAL			262	254	225	92,152	262	96.1%

REGION: II **INPATIENT INVENTORY** **FISCAL YEAR 2008**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
GREENWOOD REGIONAL REHAB HOSPITAL		GREENWOOD	GREENWOOD	NPA	12	12	255	2,533	12	57.7%
HEALTH CARE CENTER OF WESLEY COMMONS		GREENWOOD	GREENWOOD	NPA	102	102	136	33,320	102	89.3%
MAGNOLIA MANOR - GREENWOOD		GREENWOOD	GREENWOOD	PROP	88	88	61	31,726	88	98.5%
NHC HEALTHCARE - GREENWOOD		GREENWOOD	GREENWOOD	PROP	152	152	147	52,426	152	94.2%
(TRANSITIONAL CARE SELF REGIONAL)	1	GREENWOOD	GREENWOOD	NPA	0	0			0	
GREENWOOD COUNTY		TOTAL			354	354	599	120,005	354	92.6%
A SAM KARESH LONG TERM CARE CENTER	15	KERSHAW	CAMDEN	CO	96	96	96	30,601	88	95.0%
SPRINGDALE HEALTHCARE CENTER	16	KERSHAW	CAMDEN	PROP	148	148	484	48,247	148	89.1%
KERSHAW COUNTY		TOTAL			244	244	580	78,848	236	91.3%
LANCASTER CONVALESCENT CENTER		LANCASTER	LANCASTER	NPA	142	142	116	50,075	142	96.3%
TRANSITIONAL CARE UNIT - SPRINGS MEMORIAL		LANCASTER	LANCASTER	NPA	14	14	299	3,716	14	72.5%
WHITE OAK MANOR - LANCASTER		LANCASTER	LANCASTER	NPA	132	132	112	47,462	132	98.2%
LANCASTER COUNTY		TOTAL			288	288	527	101,253	288	96.1%
LAURENS COUNTY HEALTHCARE SYSTEM SNF		LAURENS	LAURENS	DIST	14	14	174	2,711	14	52.9%
MARTHA FRANK BAPTIST RETIREMENT CENTER		LAURENS	LAURENS	NPA	81	81	140	8,338	88	25.9%
(MARTHA FRANK BAPTIST RETIREMENT CENTER)		LAURENS	LAURENS	NPA	(7)	(7)				
NHC HEALTHCARE - CLINTON		LAURENS	CLINTON	PROP	131	131	100	46,700	131	97.4%
NHC HEALTHCARE - LAURENS		LAURENS	LAURENS	PROP	176	176	323	61,683	176	95.8%
PRESBYTERIAN HOME OF SC CLINTON	17	LAURENS	CLINTON	NPA	18	18				
(PRESBYTERIAN HOME OF SC CLINTON)		LAURENS	CLINTON	NPA	(48)	(48)				
LAURENS COUNTY		TOTAL			420	420	737	119,432	409	79.8%
AGAPE NURSING AND REHABILIATION CENTER		LEXINGTON	W.COLUMBIA	PROP	100	100	445	29,753	100	81.3%
BRIAN CENTER NURSING CARE - ST ANDREWS		LEXINGTON	COLUMBIA	PROP	120	120	102	39,741	120	90.5%
HEARTLAND LEXINGTON REHAB & NURSING CTR		LEXINGTON	W.COLUMBIA	PROP	132	132	363	40,806	132	84.5%
LEXINGTON MEDICAL CENTER EXTENDED CARE		LEXINGTON	LEXINGTON	NPA	388	388	600	134,834	388	94.9%
NHC HEALTHCARE - LEXINGTON		LEXINGTON	W.COLUMBIA	PROP	120	120	242	42,289	120	96.3%
PRESBYTERIAN HOME OF SC COLUMBIA	18	LEXINGTON	W COLUMBIA	NPA	44	44	50	14,427	44	89.6%
SC EPISCOPAL HOME AT STILL HOPES		LEXINGTON	W.COLUMBIA	NPA	20	20	9	5,919	20	80.9%
(SC EPISCOPAL HOME AT STILL HOPES)		LEXINGTON	W.COLUMBIA	NPA	(42)	(42)				
LEXINGTON COUNTY		TOTAL			924	924	1,811	307,769	924	91.0%
SAVANNAH HEIGHTS LIVING CENTER		MCCORMICK	MCCORMICK	CO	120	120	115	42,229	120	96.1%
MCCORMICK COUNTY		TOTAL			120	120	115	42,229	120	96.1%
J F HAWKINS NURSING HOME		NEWBERRY	NEWBERRY	CO	118	118	78	42,271	118	97.9%
NEWBERRY CO MEM HOSP - TRANS CARE UNIT		NEWBERRY	NEWBERRY	CO	12	12	193	1,740	12	39.6%
WHITE OAK MANOR - NEWBERRY		NEWBERRY	NEWBERRY	PROP	146	146	62	51,100	146	95.6%
NEWBERRY COUNTY					276	276	333	95,111	276	94.2%
COUNTRYWOOD NURSING CENTER		RICHLAND	HOPKINS	PROP	38	38	26	11,941	38	85.9%
HEARTLAND COLUMBIA REHAB & NURSING CTR	19	RICHLAND	COLUMBIA	PROP	132	132	364	42,809	132	88.6%
HERITAGE AT LOWMAN REHAB & HEALTHCARE	20	RICHLAND	WHITE ROCK	NPA	176	176	148	58,388	176	90.6%
LIFE CARE CENTER OF COLUMBIA		RICHLAND	COLUMBIA	PROP	179	179	483	59,211	179	90.4%
MAGNOLIA MANOR - COLUMBIA		RICHLAND	COLUMBIA	PROP	88	88	87	31,559	88	98.0%
NHC HEALTHCARE - PARKLANE		RICHLAND	COLUMBIA	PROP	180	180	314	62,684	180	95.1%
OAKS OF BLYTHEWOOD	21	RICHLAND	BLYTHEWOOD	PROP		120				
PALMETTO HEALTH BAPTIST SUBACUTE REHAB		RICHLAND	COLUMBIA	NPA	22	22	593	5,873	22	72.9%
RICE NURSING HOME		RICHLAND	COLUMBIA	NPA	32	32	48	10,645	32	90.9%
UNI-HEALTH POST ACUTE CARE COLUMBIA	21	RICHLAND	COLUMBIA	PROP	257	171	295	64,736	257	68.8%
WHITE OAK MANOR - COLUMBIA		RICHLAND	COLUMBIA	PROP	120	120	83	42,973	120	97.8%
WILDEWOOD DOWNS NURSING CENTER	22	RICHLAND	COLUMBIA	PROP	72	72	148	9,997	32	85.4%
(WILDEWOOD DOWNS NURSING CENTER)		RICHLAND	COLUMBIA	PROP	(8)	(8)				
(W J B DORN VA)		RICHLAND	COLUMBIA	FED		(94)				
RICHLAND COUNTY		TOTAL			1,296	1,330	2,589	400,816	1,256	87.2%
SALUDA NURSING CENTER		SALUDA	SALUDA	CO	176	176	180	61,540	176	95.5%
SALUDA COUNTY		TOTAL			176	176	180	61,540	176	95.5%

REGION: II **INPATIENT INVENTORY** **FISCAL YEAR 2008**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
AGAPE REHABILITATION ROCK HILL		YORK	ROCK HILL	PROP	99	99	404	31,629	99	87.3%
MAGNOLIA MANOR - ROCK HILL		YORK	ROCK HILL	PROP	106	106	134	37,405	106	96.4%
UNI-HEALTH POST ACUTE CARE ROCK HILL	23	YORK	ROCK HILL	PROP	132	132	168	44,374	132	91.8%
WESTMINSTER HEALTH & REHABILITATION CTR		YORK	ROCK HILL	PROP	66	66	272	21,940	66	90.8%
WHITE OAK MANOR - ROCK HILL		YORK	ROCK HILL	PROP	141	141	89	50,577	141	98.0%
WHITE OAK MANOR - YORK		YORK	YORK	NPA	109	109	100	39,010	109	97.8%
WILLOW BROOK COURT		YORK	ROCK HILL	PROP	40	40	116	11,312	40	77.3%
YORK COUNTY		TOTAL			693	693	1,283	236,247	693	93.1%
TOTAL					5,389	5,415	9,247	1,770,982	5,330	90.8%

FOOTNOTES 2010-11 PLAN

REGION II

CON	-	Certificate of Need	NPA	-	Non Profit
UC	-	Under Construction	ST	-	State
X	-	Accredited	CO	-	County
Y	-	Medicare	PROP	-	Proprietary
Z	-	Medicaid	N	-	Nursing Home
APP	-	Approved	SW	-	Statewide Facility

1. CON issued 5/19/08 to convert 20 nursing beds at Self Memorial Transitional Care Unit to general acute beds, for a total of 354 general, 24 substance abuse, and 36 psych, SC-08-16. Licensed for 354 general beds and the 20 bed TCU de-licensed on 6/12/08.
2. CON issued 10/12/07 to add 31 general beds for a total of 199 acute and 18 substance abuse beds, SC-07-49. CON approved 8/22/08 to convert 18 substance abuse beds to general beds, for a total of 217 general beds; appealed. Licensed for 199 acute and 18 substance abuse beds 12/30/08.
3. CON issued 9/14/07 for 38 additional acute beds for a total of 384 beds, SC-07-35. License increased to 354 beds 1/29/08. Licensed for 384 beds 6/13/08. CON approved 10/20/09 to add 30 beds for a total of 414; appealed. CON issued 1/21/10, SC-10-6.
4. CON approved to construct a new 76 bed hospital (Palmetto Health Parkridge) by transferring 76 beds from Palmetto Health Baptist, resulting in 287 general beds, 104 psych and 22 nursing home beds remaining at Palmetto Health Baptist; appealed.
5. CON approved 9/26/05 to convert 11 nursing home beds at Providence NE to general acute beds and to de-license the other 7 nursing home beds, for a total of 57 acute beds. Project was appealed and subsequently withdrawn 11/06. Exemption issued 3/23/06 to de-license the 18 nursing home beds at Providence Northeast, E-06-13; beds were de-licensed on 5/24/06. CON approved 8/27/07 to add 38 general beds for a total of 84 beds; appealed. SC-09-10 issued 3/3/09 after the appeal was withdrawn. Licensed beds increased from 46 to 56 on 12/3/09.
6. Bed use restricted. Beds reported by facility.
7. CON approved 5/30/06 to construct a new 100-bed hospital in Fort Mill, including the 64 beds shown as needed in the Plan plus the transfer of 36 beds from Piedmont Medical Center; appealed.
8. CON issued 7/18/06 for the addition of 32 psych beds for a total of 71 psych beds, SC-06-42. CON voided on 4/17/07, but the applicant appealed the Department's decision. After appeal, a new CON was issued 12/14/07, SC-07-65. CON issued 2/13/08 to exchange 10 substance abuse beds from Three Rivers for 10 psychiatric beds from Palmetto Baptist, for a total of 17 substance abuse and 81 psych beds at Three Rivers, SC-08-05. Licensed for 49 psych beds and 17 substance abuse beds on 7/21/08. Licensed for 81 psych beds 7/10/09.
9. CON issued 2/13/08 to exchange 10 substance abuse beds from Three Rivers for 10 psychiatric beds from Palmetto Baptist, for a total of 10 substance abuse and 94 psych beds at Palmetto Baptist, SC-08-06. Licensed for 10 substance abuse and 94 psych beds 7/21/08.
10. Licensed for 20 RTF beds 6/16/09.
11. Facility converted from a High Management Group Home, licensed 11/20/08.
12. CON issued 6/30/09 to add 6 rehab beds for a total of 46, SC-09-32.
13. CON issued 9/15/06 for a 12-bed inpatient hospice, SC-06-61.
14. CON issued 6/6/05 for construction of a 16-bed hospice, SC-05-39. Licensed 5/23/08.

15. CON issued 11/15/07 to add 8 nursing home beds that do not participate in the Medicaid program, for a total of 96 beds, SC-07-58. Licensed for 96 beds 10/1/08.
16. CON issued 1/18/08 to add 44 beds for a total of 192, SC-08-02. CON voided 7/24/09.
17. CON issued 3/12/09 to change the licensure of 18 institutional beds to community beds not participating in the Medicaid program, SC-09-14. Licensed amended 4/23/09.
18. CON issued 2/14/08 to convert 44 institutional nursing home beds to 44 general nursing home beds that do not participate in the Medicaid program, SC-08-08. Licensed as general nursing home beds 2/14/08.
19. CON issued 10/15/08 for 2 additional nursing home beds for a total of 134. CON voided 4/13/09.
20. CON approved 2/23/10 to convert 47 beds from institutional to community for a total of 176 community beds. License amended 3/24/10.
21. CON issued 1/29/07 for the construction of a 123 bed nursing home with a Medicaid Nursing Home Permit of 21,900 Medicaid patient days by transferring 89 beds from Carolina Health and Rehab and adding 34 new beds. Carolina Health and Rehab will retain 168 nursing home beds and a Medicaid Nursing Home Permit for 47,100 Medicaid patient days; SC-07-04. Name of Carolina Health and Rehab changed to UniHealth Post-Acute Columbia 6/20/08. CON amended 5/14/08 to reduce the number of beds at the Oaks of Blythewood from 123 to 120, with the number of beds retained at UniHealth Post-Acute Columbia increased from 168 to 171.
22. CON issued 9/11/08 for the addition of 8 institutional beds and 40 general nursing home beds for a total of 80 beds (8 institutional and 72 general), SC-08-35. Licensed for the additional beds on 9/10/09.
23. Formerly Rock Hill Health Care.

INVENTORY OF EMERGENCY FACILITIES 2008 UTILIZATION

CATEGORY	NAME OF FACILITY	COUNTY	CITY	2008 ER VISITS
REGION II:	EMERGENCY FACILITIES			
III	ABBEVILLE CO MEMORIAL HOSPITAL	ABBEVILLE	ABBEVILLE	10,028
II	CHESTER MEDICAL CENTER	CHESTER	CHESTER	15,318
III	EDGEFIELD COUNTY HOSPITAL	EDGEFIELD	EDGEFIELD	12,205
III	FAIRFIELD MEMORIAL HOSPITAL	FAIRFIELD	FAIRFIELD	10,523
II	SELF REGIONAL HEALTH CARE	GREENWOOD	GREENWOOD	42,503
III	KERSHAW HEALTH	KERSHAW	CAMDEN	24,288
II	SPRINGS MEMORIAL HOSPITAL	LANCASTER	LANCASTER	29,647
II	LAURENS COUNTY HOSPITAL	LAURENS	LAURENS	29,724
II	LEXINGTON MEDICAL CENTER	LEXINGTON	W. COLUMBIA	87,311
III	NEWBERRY CO MEMORIAL HOSPITAL	NEWBERRY	NEWBERRY	19,739
II	PALMETTO HEALTH BAPTIST	RICHLAND	COLUMBIA	35,802
I	PALMETTO HEALTH RICHLAND	RICHLAND	COLUMBIA	73,007
II	PROVIDENCE HOSPITAL	RICHLAND	COLUMBIA	18,501
II	PROVIDENCE HOSPITAL NORTHEAST	RICHLAND	COLUMBIA	32,655
II	PIEDMONT MEDICAL CENTER	YORK	ROCK HILL	50,623
			TOTAL	491,874

REGION II:	TRAUMA CENTERS		
III	SELF MEM REGIONAL HEALTH CARE	GREENWOOD	GREENWOOD
III	LEXINGTON MEDICAL CENTER	LEXINGTON	W. COLUMBIA
I	PALMETTO HEALTH RICHLAND	RICHLAND	COLUMBIA
III	PIEDMONT MEDICAL CTR	YORK	ROCK HILL

DETERMINATION OF REGION NEED AND NARRATIVE

REGION: III FISCAL YEAR: 2008

1. Unusual Characteristics: This region has a large transient summer population, particularly along the "Grand Strand." The inland waterway is a barrier to transportation.

2. General Hospitals: Utilization of Federal facilities is included in the inventory for information only.

3. Nursing Homes: There is a need for additional nursing home beds in this region.

4. Psychiatric Facilities: The need is determined by psychiatric service area. See Chapter II for discussion and calculation of needs.

5. Alcohol and Drug Abuse Facilities: These needs were developed in conjunction with the S.C. Department of Alcohol and Other Drug Abuse Services. See Chapter II for discussion and calculations.

6. Rehabilitation Facilities: The need is determined by rehabilitation service area. See Chapter II for discussion and calculation of needs.

REGION: III **INPATIENT INVENTORY** **FISCAL YEAR 2008**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
HOSPITALS:										
CHESTERFIELD GENERAL HOSPITAL		CHESTERFIELD	CHERAW	PROP	59	59	2,981	11,288	59	52.3%
CHESTERFIELD COUNTY		TOTAL			59	59	2,981	11,288	59	52.3%
CLARENDON MEMORIAL HOSPITAL		CLARENDON	MANNING	CO	56	56	3,002	14,025	56	68.4%
CLARENDON COUNTY		TOTAL			56	56	3,002	14,025	56	68.4%
CAROLINA PINES REGIONAL MEDICAL CENTER		DARLINGTON	HARTSVILLE	NPA	116	116	7,216	30,869	116	72.7%
MCLEOD MEDICAL CENTER - DARLINGTON		DARLINGTON	DARLINGTON	NPA	49	49	695	8,853	49	49.4%
DARLINGTON COUNTY		TOTAL			165	165	7,911	39,722	165	65.8%
MCLEOD MEDICAL CENTER - DILLON		DILLON	DILLON	NPA	79	79	3,161	11,344	79	39.2%
DILLON COUNTY		TOTAL			79	79	3,161	11,344	79	39.2%
CAROLINAS HOSPITAL SYSTEM		FLORENCE	FLORENCE	PROP	310	310	13,567	69,749	310	61.5%
LAKE CITY COMMUNITY HOSPITAL		FLORENCE	LOWER FLORENCE	DIST	48	48	1,325	4,008	48	22.8%
MCLEOD REGIONAL MEDICAL CENTER		FLORENCE	FLORENCE	NPA	453	453	23,376	118,338	453	71.4%
WOMEN'S CENTER CAROLINAS HOSP SYSTEM		FLORENCE	FLORENCE	PROP	20	20	1,239	3,629	20	49.6%
FLORENCE COUNTY		TOTAL			831	831	39,507	195,724	831	64.4%
GEORGETOWN MEMORIAL HOSPITAL	1	GEORGETOWN	GEORGETOWN	NPA	131	131	6,029	26,561	131	55.4%
WACCAMAW COMMUNITY HOSPITAL	2	GEORGETOWN	MURRELLS INLET	NPA	124	124	6,261	26,085	87.4	81.5%
GEORGETOWN COUNTY		TOTAL			255	255	12,290	52,646	218.4	65.9%
CONWAY HOSPITAL	3	HORRY	CONWAY	NPA	210	210	9,274	37,407	160	63.9%
GRAND STRAND REGIONAL MEDICAL CENTER	4	HORRY	MYRTLE BEACH	PROP	219	269	12,929	58,284	219	72.7%
LORIS COMMUNITY HOSPITAL		HORRY	LORIS	DIST	105	105	427	15,094	105	39.3%
SEACOAST MEDICAL CENTER	5	HORRY	LITTLE RIVER	DIST		50				
HORRY COUNTY		TOTAL			534	634	22,630	110,785	484	62.5%
MARION COUNTY MEDICAL CENTER		MARION	MARION	DIST	124	124	4,659	19,122	124	42.1%
MARION COUNTY		TOTAL			124	124	4,659	19,122	124	42.1%
MARLBORO PARK HOSPITAL		MARLBORO	BENNETTSVILLE	PROP	94	94	1,818	5,308	94	15.4%
MARLBORO COUNTY		TOTAL			94	94	1,818	5,308	94	15.4%
TUOMEY		SUMTER	SUMTER	NPA	283	283	8,836	69,057	283	66.7%
SUMTER COUNTY		TOTAL			283	283	8,836	69,057	283	66.7%
WILLIAMSBURG REGIONAL HOSPITAL		WILLIAMSBURG	KINGSTREE	CO	25	25	514	1,419	25	15.5%
WILLIAMSBURG COUNTY		TOTAL			25	25	514	1,419	25	15.5%
TOTAL					2,505	2,605	107,309	530,440	2,418	59.9%
LONG TERM ACUTE HOSPITALS:										
REGENCY HOSPITAL OF SOUTH CAROLINA		FLORENCE	FLORENCE	PROP	40	40	413	10,796	40	73.7%
TOTAL					40	40	413	10,796	40	73.7%
MENTAL FACILITIES:										
MCLEOD MEDICAL CENTER - DARLINGTON		DARLINGTON	DARLINGTON	NPA	23	23	565	4,647	23	55.2%
DARLINGTON COUNTY		TOTAL			23	23	565	4,647	23	55.2%
CAROLINAS HOSP SYS - CEDAR TOWERS		FLORENCE	FLORENCE	PROP	12	12	181	1,587	12	36.1%
FLORENCE COUNTY		TOTAL			12	12	181	1,587	12	36.1%
LIGHTHOUSE CARE CENTER OF CONWAY	6	HORRY	CONWAY	PROP	44	59	1,162	10,466	44	65.0%
HORRY COUNTY		TOTAL			44	59	1,162	10,466	44	65.0%
MARLBORO PARK HOSPITAL		MARLBORO	BENNETTSVILLE	PROP	8	8	0	0	8	0.0%
MARLBORO COUNTY		TOTAL			8	8	0	0	8	0.0%
TOTAL					87	102	1,908	16,700	87	52.4%

REGION: III **INPATIENT INVENTORY** **FISCAL YEAR 2008**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS:										
PALMETTO PEE DEE RES TREATMENT CTR		FLORENCE	FLORENCE	PROP	59	59	31	10,356	59	48.0%
LIGHTHOUSE CARE CENTER OF CONWAY	6	HORRY	CONWAY	PROP	30	30	16	5,789	16	98.9%
WILLOWGLEN ACADEMY SOUTH CAROLINA	7	WILLIAMSBURG	GREELEYVILLE	PROP	40	40				
TOTAL					**129**	**129**	**47**	**16,145**	**75**	**58.8%**
DRUG AND ALCOHOL INPATIENT TREATMENT:										
CAROLINAS HOSPITAL SYSTEM - CEDAR TOWERS		FLORENCE	FLORENCE	PROP	12	12	387	1,867	12	42.5%
LIGHTHOUSE CARE CENTER OF CONWAY	6	HORRY	CONWAY	PROP	8	14	347	2,440	8	83.3%
TOTAL					**20**	**26**	**734**	**4,307**	**20**	**58.8%**
REHABILITATION FACILITIES:										
CAROLINAS HOSPITAL SYSTEM - CEDAR TOWERS		FLORENCE	FLORENCE	NPA	42	42	735	10,830	42	70.5%
HEALTHSOUTH REHAB HOSPITAL FLORENCE		FLORENCE	FLORENCE	PROP	88	88	1,114	17,592	88	54.6%
FLORENCE COUNTY		TOTAL			130	130	1,849	28,422	130	59.7%
WACCAMAW COMMUNITY HOSPITAL	2	GEORGETOWN	MURRELLS INLET	NPA	43	43	788	9,220	30.8	81.8%
GEORGETOWN COUNTY		TOTAL			43	43	788	9,220	30.8	81.8%
TOTAL					**173**	**173**	**2,637**	**37,642**	**161**	**64.0%**
INPATIENT HOSPICE FACILITIES:										
MCLEOD HOSPICE HOUSE	8	FLORENCE	FLORENCE	NPA	12	24	452	3,789	12	86.3%
TIDELANDS COMMUNITY HOSPICE HOUSE		GEORGETOWN	GEORGETOWN	NPA	12	12	187	1,725	12	39.3%
AGAPE HOSPICE HOUSE OF HORRY COUNTY	9	HORRY	CONWAY	PROP	24	24				
TOTAL					**48**	**60**	**639**	**5,514**	**24**	**62.8%**
LONG TERM FACILITIES:										
CHERAW HEALTHCARE	10	CHESTERFIELD	CHERAW	PROP	120	120	54	37,300	111.1	91.7%
CHESTERFIELD CONVALESCENT CENTER		CHESTERFIELD	CHERAW	PROP	104	104	48	36,743	104	96.5%
CHESTERFIELD COUNTY		TOTAL			224	224	102	74,043	215	94.1%
LAKE MARION NURSING FACILITY		CLARENDON	SUMMERTON	PROP	88	88	81	29,388	88	91.2%
WINDSOR MANOR		CLARENDON	MANNING	PROP	64	43	33	22,044	64	94.1%
CLARENDON COUNTY		TOTAL			152	131	114	51,432	152	92.5%
BETHEA BAPTIST HEALTH CARE CENTER		DARLINGTON	DARLINGTON	NPA	36	36	45	11,156	36	84.7%
(BETHEA BAPTIST HEALTH CARE CENTER)		DARLINGTON	DARLINGTON	NPA	(52)	(52)				
MEDFORD NURSING CENTER		DARLINGTON	DARLINGTON	PROP	88	88	45	31,075	88	96.5%
MORRELL NURSING CENTER		DARLINGTON	HARTSVILLE	PROP	154	154	211	51,262	154	90.9%
OAKHAVEN NURSING CENTER		DARLINGTON	DARLINGTON	PROP	88	88	52	31,413	88	97.5%
DARLINGTON COUNTY		TOTAL			366	366	353	124,906	366	93.2%
HERITAGE HEALTHCARE AT THE PINES		DILLON	DILLON	PROP	84	84	47	30,305	84	98.6%
SUNNY ACRES		DILLON	FORK	PROP	111	111	60	39,960	111	98.4%
DILLON COUNTY		TOTAL			195	195	107	70,265	195	98.5%
CAROLINAS HOSP SYS TRANS CARE UNIT		FLORENCE	FLORENCE	PROP	24	24	440	5,220	24	59.4%
COMMANDER NURSING CENTER		FLORENCE	FLORENCE	PROP	163	152	111	58,461	163	98.0%
COOKE ASSOCIATES OF FLORENCE		FLORENCE	FLORENCE	PROP	88	88	100	28,783	88	89.4%
FAITH HEALTHCARE CENTER		FLORENCE	FLORENCE	PROP	104	93	88	35,553	104	93.4%

REGION: III **INPATIENT INVENTORY** **FISCAL YEAR 2008**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
HERITAGE HOME OF FLORENCE		FLORENCE	FLORENCE	PROP	132	132	74	47,748	132	98.8%
HONORAGE NURSING CENTER		FLORENCE	FLORENCE	PROP	88	88	66	31,485	88	97.8%
LAKE CITY - SCRANTON HEALTH CARE CTR		FLORENCE	SCRANTON	PROP	88	88	88	7,748	88	24.1%
SOUTHLAND HEALTH CARE CENTER		FLORENCE	FLORENCE	PROP	88	88	43	31,607	88	98.1%
FLORENCE COUNTY		TOTAL			775	753	1,010	246,605	775	86.9%
GEORGETOWN HEALTH AND REHAB		GEORGETOWN	GEORGETOWN	PROP	84	84	42	27,897	84	90.7%
LAKES AT LITCHFIELD SKILLED NURS CTR		GEORGETOWN	PAWLEYS ISLAND	PROP	17	17	111	4,258	17	68.4%
(LAKES AT LITCHFIELD SKILLED NURS CTR)		(GEORGETOWN)	(PAWLEYS ISLAND)	(PROP)	(7)	(7)				
PRINCE GEORGE HEALTHCARE CENTER		GEORGETOWN	GEORGETOWN	PROP	148	148	214	8,346	148	15.4%
GEORGETOWN COUNTY		TOTAL			249	249	367	40,501	249	44.4%
AGAPE REHABILITATION CTR CONWAY	11	HORRY	CONWAY	PROP	72	72				
BRIGHTWATER SKILLED NURSING CENTER	12	HORRY	MYRTLE BEACH	PROP	32	32				
CONWAY MANOR	13	HORRY	CONWAY	PROP	190	190	266	66,311	190	95.4%
COVENANT TOWERS HEALTH CARE		HORRY	MYRTLE BEACH	PROP	30	30	154	8,497	30	77.4%
GRAND STRAND HEALTH CARE		HORRY	CONWAY	PROP	88	88	109	31,248	88	97.0%
KINGSTON NURSING CENTER		HORRY	CONWAY	PROP	88	88	272	31,064	88	96.4%
LORIS EXTENDED CARE CENTER		HORRY	LORIS	DIST	88	88	239	30,050	88	93.3%
MYRTLE BEACH MANOR	14	HORRY	MYRTLE BEACH	PROP	100	100	444	31,703	104	83.3%
NHC HEALTHCARE - GARDEN CITY		HORRY	MYRTLE BEACH	PROP	148	148	516	50,026	148	92.4%
SHEPHERD'S LANDING NURSING & REHAB CTR	15	HORRY	LITTLE RIVER	PROP	0	60				
HORRY COUNTY		TOTAL			836	896	2,000	248,899	736	92.4%
MCCOY MEMORIAL NURSING CENTER		LEE	BISHOPVILLE	PROP	120	120	126	42,686	120	97.2%
LEE COUNTY		TOTAL			120	120	126	42,686	120	97.2%
MARION NURSING CENTER		MARION	MARION	PROP	88	88	39	31,048	88	96.4%
MULLINS NURSING CENTER		MARION	MARION	NPA	92	92	32	33,383	92	99.1%
MARION COUNTY		TOTAL			180	180	71	64,431	180	97.8%
DUNDEE MANOR		MARLBORO	BENNETTSVILLE	PROP	110	110	84	36,708	110	91.2%
MARLBORO COUNTY		TOTAL			110	110	84	36,708	110	91.2%
HOPEWELL HEALTH CARE CENTER		SUMTER	SUMTER	PROP	96	96	37	33,841	96	96.3%
NHC HEALTHCARE - SUMTER		SUMTER	SUMTER	PROP	138	138	110	48,234	138	95.5%
SUMTER EAST HEALTH & REHAB CENTER		SUMTER	SUMTER	PROP	176	176	160	62,282	176	96.7%
TUOMEY SUBACUTE SKILLED CARE		SUMTER	SUMTER	NPA	18	18	414	4,217	18	64.0%
SUMTER COUNTY		TOTAL			428	428	721	148,574	428	94.8%
DR. RONALD E. MCNAIR NURSING & REHAB		WILLIAMSBURG	CADES	PROP	88	88	61	28,790	88	89.4%
KINGSTREE NURSING FACILITY		WILLIAMSBURG	KINGSTREE	PROP	96	96	56	32,485	96	92.5%
WILLIAMSBURG COUNTY		TOTAL			184	184	117	61,275	184	91.0%
TOTAL					3,819	3,836	5,172	1,210,325	3,710	89.1%

FOOTNOTES 2010-11 PLAN

REGION III

CON	-	Certificate of Need	NPA	-	Non Profit
UC	-	Under Construction	ST	-	State
X	-	Accredited	CO	-	County
Y	-	Medicare	PROP	-	Proprietary
Z	-	Medicaid	N	-	Nursing Home
APP	-	Approved	SW	-	Statewide Facility

1. CON issued 3/2/09 to construct a replacement of the existing hospital, with a decrease in bed capacity from 131 to 129 beds, SC-09-09.
2. CON issued 6/15/07 to add 42 general beds and 14 rehab beds, for a total of 124 general and 43 rehab beds, SC-07-22. Licensed for 124 general and 43 rehab beds, 8/15/08.
3. CON issued 2/1/06 to add 50 general beds for a total of 210 general beds, SC-06-04. Licensed for 210 beds 7/16/09.
4. CON approved 9/4/07 to add 50 general acute beds for a total of 269.
5. CON approved 8/29/05 to establish a hospital with 50 general acute beds; appealed. CON issued per ALJ Order 9/28/07, SC-07-47.
6. Number of licensed RTF beds increased from 16 to 30 10/29/09. CON approved to add 15 psych beds, for a total of 59, and 6 inpatient substance abuse beds, for a total of 14; appealed. Appeal withdrawn, CON SC-10-07 issued 1/25/10.
7. Converted from a High Maintenance Group Home to a 40 bed Residential Treatment Facility on 3/20/09.
8. CON approved to add 12 beds for a total of 24, 2/23/10.
9. CON issued 3/5/07 for a 24-bed inpatient hospice, SC-07-08. Licensed 3/31/09.
10. CON approved 6/26/07 to construct a replacement facility and add 17 beds that do not participate in the Medicaid program for a 117 bed nursing home. New facility licensed for 117 beds 5/1/08. CON issued 4/16/09 to add 3 beds for a total of 120, SC-09-17. Licensed for 120 beds 7/24/09.
11. CON issued 3/5/07 for a 72-bed nursing home that does not participate in the Medicaid program/ SC-07-07. Facility licensed 3/18/09.
12. CON issued 5/9/08 for a 32-bed nursing home that does not participate in the Medicaid program, SC-08-15. Licensed 4/13/09.
13. 2007 Data.
14. De-licensed 4 nursing home beds for a total of 100 beds, 2/22/10.
15. CON issued 3/12/09 for a 60 bed nursing home that does not participate in the Medicaid program, SC-09-12.

INVENTORY OF EMERGENCY FACILITIES 2008 UTILIZATION

CATEGORY	NAME OF FACILITY	COUNTY	CITY	2008 ER VISITS
REGION III:	EMERGENCY FACILITIES			
II	CHESTERFIELD GENERAL HOSPITAL	CHESTERFIELD	CHERAW	13,439
III	CLARENDON MEMORIAL HOSPITAL	CLARENDON	MANNING	17,882
III	CAROLINA PINES REGIONAL MED CTR	DARLINGTON	HARTSVILLE	29,599
III	MCLEOD - DILLON	DILLON	DILLON	24,521
III	CAROLINAS HOSPITAL SYSTEM	FLORENCE	FLORENCE	35,679
II	MCLEOD REGIONAL MED CENTER	FLORENCE	FLORENCE	61,025
III	LAKE CITY COMMUNITY HOSPITAL	FLORENCE	LAKE CITY	16,716
II	GEORGETOWN MEMORIAL HOSPITAL	GEORGETOWN	GEORGETOWN	30,820
II	WACCAMAW COMMUNITY HOSPITAL	GEORGETOWN	MURRELLS INLET	25,117
II	CONWAY HOSPITAL	HORRY	CONWAY	43,590
III	LORIS COMMUNITY HOSPITAL	HORRY	LORIS	39,618
II	GRAND STRAND REGIONAL MED CTR	HORRY	MYRTLE BEACH	66,344
III	MARION COUNTY MEDICAL CENTER	MARION	MARION	22,647
III	MARLBORO PARK HOSPITAL	MARLBORO	BENNETTSVILLE	12,352
II	TUOMEY	SUMTER	SUMTER	52,264
III	WILLIAMSBURG REGIONAL	WILLIAMSBURG	KINGSTREE	11,117
			TOTAL	502,730

REGION III:	TRAUMA CENTERS		
III	CAROLINA PINES REGIONAL MED CTR	DARLINGTON	HARTSVILLE
III	CAROLINAS HOSPITAL SYSTEM	FLORENCE	FLORENCE
III	MCLEOD REGIONAL MED CENTER	FLORENCE	FLORENCE
III	CONWAY HOSPITAL	HORRY	CONWAY
III	LORIS COMMUNITY HOSPITAL	HORRY	LORIS
III	GRAND STRAND REGIONAL MED CTR	HORRY	MYRTLE BEACH

DETERMINATION OF REGION NEED AND NARRATIVE

REGION: IV FISCAL YEAR: 2008

1. Unusual Characteristics: This region has a military presence in Charleston. A naval hospital provides health care services for the active duty and dependents residing in this region. A 376 bed Veterans Administration Hospital is located in Charleston. The only medical university hospital in the State is located in Charleston. The Marine Air Base and Parris Island Marine Base are located near Beaufort with naval hospital to provide care to the active duty and dependents. The sea islands, rivers and sounds are barriers to transportation.

2. General Hospitals: Utilization of Federal facilities is included in the inventory for information only.

3. Nursing Homes: There is a need for additional nursing home beds in this region.

4. Psychiatric Facilities: The need is determined by psychiatric service area. See Chapter II for discussion and calculation of needs.

5. Alcohol and Drug Abuse Facilities: These needs were developed in conjunction with the S.C. Department of Alcohol and Other Drug Abuse Services. See Chapter II for discussion and calculations. The William J. McCord Adolescent Treatment Center in Orangeburg County serves adolescents exclusively from throughout the state.

6. Rehabilitation Facilities: The need is determined by rehabilitation service area. See Chapter II for discussion and calculation of needs.

REGION: IV **INPATIENT INVENTORY** **FISCAL YEAR 2008**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
HOSPITALS:										
AIKEN REGIONAL MEDICAL CENTER		AIKEN	AIKEN	PROP	183	183	8,959	41,451	183	61.9%
AIKEN COUNTY		TOTAL			183	183	8,959	41,451	183	61.9%
ALLENDALE COUNTY HOSPITAL		ALLENDALE	FAIRFAX	CO	25	25	306	1,325	25	14.5%
ALLENDALE COUNTY HOSPITAL		TOTAL			25	25	306	1,325	25	14.5%
BAMBERG COUNTY MEMORIAL	1	BAMBERG	BAMBERG	CO	59	59	1,197	2,098	59	9.7%
BAMBERG COUNTY		TOTAL			59	59	1,197	2,098	59	9.7%
BARNWELL COUNTY HOSPITAL		BARNWELL	BARNWELL	CO	53	53	1,183	3,660	53	18.9%
BARNWELL COUNTY		TOTAL			53	53	1,183	3,660	53	18.9%
BEAUFORT COUNTY MEMORIAL		BEAUFORT	BEAUFORT	CO	169	169	9,682	39,553	169	63.9%
HILTON HEAD HOSPITAL		BEAUFORT	HILTON HEAD	NPA	93	93	4,738	18,694	93	54.9%
NAVAL HOSPITAL	2	BEAUFORT	BEAUFORT	FED		(64)				
BEAUFORT COUNTY		TOTAL			262	262	14,420	58,247	262	60.7%
BERKELEY MEDICAL CENTER	3	BERKELEY	MONCKS CORNER	PROP		50				
ROPER ST FRANCIS HOSPITAL - BERKELEY	4	BERKELEY	GOOSE CREEK	NPA		50				
BERKELEY COUNTY		TOTAL			0	100	0	0		
BON-SECOURS ST. FRANCIS XAVIER	5	CHARLESTON	CHARLESTON	NPA	204	204	8,428	34,729	188.1	50.4%
CHARLESTON MEMORIAL HOSPITAL	6	CHARLESTON	CHARLESTON	CO	0	0	87	6,407	65.2	26.8%
EAST COOPER MEDICAL CENTER	7	CHARLESTON	MT PLEASANT	PROP	129	130	5,432	18,026	100	49.3%
MEDICAL UNIVERSITY HOSPITAL	6	CHARLESTON	CHARLESTON	ST	584	604	28,595	138,215	498.6	75.7%
ROPER HOSPITAL	5	CHARLESTON	CHARLESTON	NPA	401	266	15,230	83,195	402.8	56.4%
ROPER ST. FRANCIS MOUNT PLEASANT HOSP	5	CHARLESTON	MT PLEASANT	NPA		85				
TRIDENT MEDICAL CENTER	8	CHARLESTON	CHARLESTON	PROP	296	296	15,112	72,132	287.7	68.5%
RALPH H JOHNSON VETERANS MEDICAL CTR	2	CHARLESTON	CHARLESTON	FED		(144)				
CHARLESTON COUNTY		TOTAL			1,614	1,585	72,884	352,704	1,542.4	62.5%
COLLETON MEDICAL CENTER		COLLETON	WALTERBORO	PROP	131	131	3,881	22,318	131	46.5%
COLLETON COUNTY		TOTAL			131	131	3,881	22,318	131	46.5%
SUMMERVILLE MEDICAL CENTER		DORCHESTER	SUMMERVILLE	PROP	94	94	5,577	20,907	94	60.8%
DORCHESTER COUNTY		TOTAL			94	94	5,577	20,907	94	60.8%
HAMPTON REGIONAL MEDICAL CENTER	9	HAMPTON	VARNVILLE	CO	32	32	975	3,062	68	12.3%
HAMPTON COUNTY		TOTAL			32	32	975	3,062	68	12.3%
COASTAL CAROLINA MEDICAL CENTER		JASPER	HARDEEVILLE	PROP	31	31	1,099	3,816	31	33.6%
JASPER COUNTY		TOTAL			31	31	1,099	3,816	31	33.6%
REGIONAL MED CTR ORANGEBURG-CALHOUN		ORANGEBURG	ORANGEBURG	CO	247	247	10,378	53,854	247	59.6%
ORANGEBURG COUNTY		TOTAL			247	247	10,378	53,854	247	59.6%
TOTAL					2,731	2,802	120,859	563,442	2,695	57.1%
LONG TERM ACUTE HOSPITALS:										
(SAVANNAH RIVER SPECIALTY HOSPITAL)	10	AIKEN	AIKEN	PROP	(0)	(0)				
KINDRED HOSPITAL - CHARLESTON		CHARLESTON	CHARLESTON	PROP	59	59	272	10,875	59	50.4%
TOTAL					59	59	272	10,875	59	50.4%
MENTAL FACILITIES:										
AIKEN REGIONAL MEDICAL CENTER		AIKEN	AIKEN	PROP	29	29	1,352	10,400	29	98.0%
AIKEN COUNTY		TOTAL			29	29	1,352	10,400	29	98.0%
BEAUFORT MEMORIAL HOSPITAL		BEAUFORT	BEAUFORT	CO	14	14	356	2,433	14	47.5%
BEAUFORT COUNTY		TOTAL			14	14	356	2,433	14	47.5%
CHARLESTON MEMORIAL HOSPITAL	6	CHARLESTON	CHARLESTON	CO	0	0	0	0	8.7	0.0%
MEDICAL UNIVERSITY HOSPITAL		CHARLESTON	CHARLESTON	ST	82	82	2,715	20,862	73.3	77.8%
PALMETTO LOWCOUNTY BEHAVIORAL HEALTH	11	CHARLESTON	CHARLESTON	PROP	70	70	1,909	14,414	67.6	58.3%
RALPH H JOHNSON VETERANS MEDICAL CTR	2	CHARLESTON	CHARLESTON	FED		(36)				

REGION: IV **INPATIENT INVENTORY** **FISCAL YEAR 2008**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
CHARLESTON COUNTY		TOTAL			152	152	4,624	35,276	150	64.4%
REGIONAL MED CTR ORANGEBURG-CALHOUN		ORANGEBURG	ORANGEBURG	CO	15	15	281	3,290	15	59.9%
ORANGEBURG COUNTY		TOTAL			15	15	281	3,290	15	59.9%
TOTAL					**210**	**210**	**6,613**	**51,399**	**208**	**67.6%**
RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN & ADOLESCENTS:										
PALMETTO LOWCOUNTY BEHAV. HEALTH RTC		CHARLESTON	CHARLESTON	PROP	32	32	70	11,161	32	95.3%
RIVERSIDE BEHAVIORAL AT WINDWOOD FARM	12	CHARLESTON	AWENDAW	PROP	12	12				
PALMETTO PINES BEHAVIORAL HEALTH		SUMMERVILLE	DORCHESTER	PROP	60	60	56	20,336	60	92.6%
TOTAL					**104**	**104**	**126**	**31497**	**92**	**93.5%**
DRUG AND ALCOHOL INPATIENT TREATMENT:										
AIKEN REGIONAL MEDICAL CENTER		AIKEN	AIKEN	PROP	18	18	336	1,743	18	26.5%
PALMETTO LOWCOUNTY BEHAVIORAL HEALTH		CHARLESTON	N CHARLESTON	PROP	10	10	550	3,626	10	99.1%
MEDICAL UNIVERSITY HOSPITAL		CHARLESTON	CHARLESTON	ST	23	23	535	2,913	23	34.6%
TOTAL					**51**	**51**	**1,421**	**8,282**	**51**	**44.4%**
REHABILITATION FACILITIES:										
BEAUFORT MEMORIAL HOSPITAL		BEAUFORT	BEAUFORT	CO	14	14	247	2,764	14	53.9%
BEAUFORT COUNTY		TOTAL			14	14	247	2,764	14	53.9%
ROPER HOSPITAL	5	CHARLESTON	CHARLESTON	NPA	52	52	835	11,740	39	82.2%
HEALTHSOUTH CHARLESTON		CHARLESTON	CHARLESTON	PROP	46	46	952	13,394	46	79.6%
CHARLESTON COUNTY		TOTAL			98	98	1,787	25,134	85	80.8%
COASTAL CAROLINA MEDICAL CENTER		JASPER	HARDEEVILLE	PROP	10	10	128	1,759	10	48.1%
JASPER COUNTY		TOTAL			10	10	128	1,759	10	48.1%
REGIONAL MED CTR ORANGEBURG-CALHOUN		ORANGEBURG	ORANGEBURG	CO	24	24	325	3,290	24	37.5%
ORANGEBURG COUNTY		TOTAL			24	24	325	3,290	24	37.5%
TOTAL					**146**	**146**	**2,487**	**32,947**	**133**	**67.7%**
INPATIENT HOSPICE FACILITIES:										
THE HOSPICE OF CHARLESTON		CHARLESTON	CHARLESTON	NPA	20	20	538	5,413	20	73.9%
TOTAL					**20**	**20**	**538**	**5,413**	**20**	**73.9%**
LONG TERM FACILITIES:										
AZALEA WOODS		AIKEN	AIKEN	PROP	86	86	45	29,703	86	94.4%
CARRIAGE HILLS LIVING CENTER		AIKEN	AIKEN	PROP	60	60	448	20,657	60	94.1%
HERITAGE HEALTHCARE AT MATTIE HALL		AIKEN	AIKEN	PROP	176	176	320	58,942	176	91.5%
NHC HEALTHCARE N. AUGUSTA	13	AIKEN	N. AUGUSTA	PROP	192	192	253	52,918	132	109.5%
PEPPER HILL NURSING CENTER		AIKEN	AIKEN	PROP	132	132	192	45,271	132	93.7%
(SAVANNAH RIVER SPECIALTY HOSPITAL)	10	AIKEN	AIKEN	PROP	(0)	(0)				
UNIHEALTH POST-ACUTE - NORTH AUGUSTA		AIKEN	N. AUGUSTA	PROP	132	132			125	0.0%
AIKEN COUNTY		TOTAL			778	778	1,258	207,491	711	79.7%
JOHN E HARTER NURSING HOME		ALLENDALE	FAIRFAX	CO	44	44	23	13,277	44	82.4%
ALLENDALE COUNTY		TOTAL			44	44	23	13,277	44	82.4%
UNIHEALTH POST-ACUTE CARE BAMBERG	14	BAMBERG	BAMBERG	CO	88	88			88	0.0%
BAMBERG COUNTY		TOTAL			88	88	0	0	88	0.0%
BARNWELL COUNTY NURSING HOME	15	BARNWELL	BARNWELL	CO	44	44	51	14,387	44	89.3%
LAUREL BAYE HEALTHCARE OF BLACKVILLE		BARNWELL	BLACKVILLE	PROP	85	85	41	29,370	85	94.4%
LAUREL BAYE HEALTHCARE OF WILLISTON		BARNWELL	WILLISTON	PROP	44	44	81	15,240	44	94.6%
BARNWELL COUNTY		TOTAL			173	173	173	58,997	173	93.2%

REGION: IV **INPATIENT INVENTORY** **FISCAL YEAR 2008**

NAME OF FACILITY	FN	COUNTY	CITY	CON-TROL	LICENSED BEDS	SURVEY BEDS	ADMIS SIONS	PATIENT DAYS	AVE LIC BEDS	% OCCU RATE
BAYVIEW MANOR		BEAUFORT	BEAUFORT	PROP	170	170	307	52,587	170	84.5%
BEACON HARBOR SUBACUTE CARE	16	BEAUFORT	BLUFTON	PROP		120				
BROAD CREEK		BEAUFORT	HILTON HEAD	PROP	25	25	93	9,027	25	98.7%
LIFE CARE CENTER OF HILTON HEAD		BEAUFORT	HILTON HEAD	PROP	88	88	228	29,962	88	93.0%
FRASER HEALTH CENTER		BEAUFORT	HILTON HEAD	PROP	19	19	58	5,840	19	84.0%
(FRASER HEALTH CENTER)		(BEAUFORT)	(HILTON HEAD)	PROP	(14)	(14)				
NHC BLUFFTON	17	BEAUFORT	BLUFTON	PROP	120	120				
PRESTON HEALTH CARE CENTER		BEAUFORT	HILTON HEAD	PROP	69	69	126	15,202	69	60.2%
(PRESTON HEALTH CARE CENTER)		(BEAUFORT)	(HILTON HEAD)	PROP	(8)	(8)				
BEAUFORT COUNTY		TOTAL			491	611	812	112,618	371	82.9%
HEARTLAND HEALTH CARE CTR - CHARLESTON	18	BERKELEY	HANAHAN	PROP	105	135	362	31,900	105	83.0%
LAKE MOULTRIE NURSING HOME		BERKELEY	ST STEPHENS	PROP	88	88	55	30,697	88	95.3%
UNIHEALTH POST-ACUTE MONCKS CORNER		BERKELEY	MONCKS CORNER	PROP	132	132	123	44,895	132	92.9%
BERKELEY COUNTY		TOTAL			325	355	540	107,492	325	90.4%
CALHOUN CONVALESCENT CENTER		CALHOUN	ST. MATTHEWS	PROP	120	120	98	41,760	120	95.1%
CALHOUN COUNTY		TOTAL			120	120	98	41,760	120	95.1%
BISHOP GADSDEN EPISCOPAL HOME		CHARLESTON	CHARLESTON	NPA	41	41	43	13,734	41	91.5%
(BISHOP GADSDEN EPISCOPAL HOME)		CHARLESTON	CHARLESTON	NPA	(9)	(9)				
DRIFTWOOD REHAB. & NURSING CENTER		CHARLESTON	CHARLESTON	PROP	160	160	124	56,334	160	96.2%
FRANKE HEALTH CARE CENTER		CHARLESTON	CHARLESTON	NPA	24	24	43	8,249	24	93.9%
(FRANKE HEALTH CARE CENTER)		CHARLESTON	CHARLESTON	NPA	(20)	(20)				
GRACE HALL - REHABILITATION	19	CHARLESTON	MT. PLEASANT	PROP	42	42	63	12,120	42	78.8%
HEARTLAND WEST ASHLEY REHAB & NURSING CTR	20	CHARLESTON	CHARLESTON	NPA	99	125	567	33,477	99	92.4%
ISLAND OAKS LIVING CENTER		CHARLESTON	CHARLESTON	NPA	132	132	101	48,048	132	99.5%
LIFE CARE CENTER - CHARLESTON		CHARLESTON	N CHARLESTON	PROP	148	148	524	52,145	148	96.3%
MOUNT PLEASANT MANOR		CHARLESTON	MT. PLEASANT	PROP	132	132	151	45,941	132	95.1%
NATIONAL HEALTH CARE CHARLESTON	21	CHARLESTON	CHARLESTON	PROP	132	132				
SANDPIPER REHAB & NURSING		CHARLESTON	MT. PLEASANT	PROP	176	176	345	60,979	176	94.7%
(TRIDENT SKILLED NURSING CENTER)	8	CHARLESTON	CHARLESTON	PROP	(0)	(0)			25	0.0%
WHITE OAK MANOR - CHARLESTON		CHARLESTON	CHARLESTON	PROP	176	176	163	60,652	176	94.2%
CHARLESTON COUNTY		TOTAL			1,262	1,288	2,124	391,679	1,155	92.7%
HERITAGE HEALTHCARE OF THE LOWCOUNTRY		COLLETON	WALTERBORO	PROP	132	132	224	45,062	132	93.3%
COLLETON COUNTY		TOTAL			132	132	224	45,062	132	93.3%
HALLMARK HEALTHCARE CENTER		DORCHESTER	SUMMERVILLE	PROP	88	88	187	31,240	88	97.0%
OAKBROOK HEALTHCARE CENTER		DORCHESTER	SUMMERVILLE	PROP	88	88			88	0.0%
PRESBYTERIAN HOME SUMMERVILLE	22	DORCHESTER	SUMMERVILLE	NPA	87	87	21	13,307	87	41.8%
ST GEORGE HEALTH CARE CENTER		DORCHESTER	ST. GEORGE	PROP	88	88	154	28,936	88	89.8%
DORCHESTER COUNTY		TOTAL			351	351	362	73,483	351	57.2%
UNI-HEALTH POST ACUTE CARE - LOWCOUNTRY		HAMPTON	ESTILL	CO	104	104	156	34,425	104	90.4%
HAMPTON COUNTY		TOTAL			104	104	156	34,425	104	90.4%
RIDGELAND NURSING CENTER		JASPER	RIDGELAND	PROP	88	88	65	31,589	88	98.1%
JASPER COUNTY		TOTAL			88	88	65	31,589	88	98.1%
LAUREL BAYE HEALTHCARE ORANGEBURG		ORANGEBURG	ORANGEBURG	PROP	113	113	263	35,137	113	85.0%
JOLLEY ACRES HEALTHCARE CENTER		ORANGEBURG	ORANGEBURG	PROP	60	60	116	21,088	60	96.0%
UNIHEALTH POST-ACUTE CARE ORANGEBURG	23	ORANGEBURG	ORANGEBURG	PROP	88	88	73	30,955	88	96.1%
THE METHODIST OAKS		ORANGEBURG	ORANGEBURG	NPA	132	132	229	42,832	132	88.7%
ORANGEBURG COUNTY		TOTAL			393	393	681	130,012	393	90.4%
TOTAL					**4,349**	**4,525**	**5,258**	**1,040,394**	**3,344**	**85.0%**

FOOTNOTES 2010-11 PLAN

REGION IV

CON	-	Certificate of Need	NPA	-	Non Profit
UC	-	Under Construction	ST	-	State
X	-	Accredited	CO	-	County
Y	-	Medicare	PROP	-	Proprietary
Z	-	Medicaid	N	-	Nursing Home
APP	-	Approved	SW	-	Statewide Facility

1. CON approved 10/24/06 to construct a replacement hospital; appealed. CON issued after ALJ Order to Dismiss 9/14/07, SC-07-36. 2008 ORS utilization data.
2. Bed use restricted.
3. CON approved 6/26/09 to construct a new 50 bed hospital in Berkeley County using the bed need generated by Trident Medical Center. Appealed.
4. CON approved 6/26/09 to construct a new 50 bed hospital (Roper St. Francis Hospital – Berkeley) by transferring 50 existing beds from Roper Hospital. Appealed.
5. CON issued 6/24/05 to construct 50 additional beds at St. Francis Xavier and transfer 13 beds from Roper Hospital, for a total of 204 general acute beds at St. Francis Xavier and 401 general beds at Roper Hospital, SC-05-43. On 1/31/06, 3 additional general beds were licensed at St. Francis Xavier for a total of 144 general beds. CON issued 5/31/06 to construct a new hospital in Mount Pleasant by transferring 85 acute beds from Roper Hospital, SC-06-27. The approval requires that the applicant not commence construction on the project until 2 years (24 months) from the date of issuance of the CON. The number of licensed beds at St. Francis Xavier increased from 144 to 168 2/20/08. Of these 24 additional beds, 13 were transferred from Roper and 11 were new beds. Roper license decreased from 414 to 401 general acute beds 2/20/08. St. Francis Xavier licensed for 204 general acute beds 5/8/08. CON approved 10/16/07 to add 13 rehabilitation beds at Roper for a total of 52; appealed. Case dismissed by ALJ Order 8/29/08. Licensed for 52 rehab beds 10/28/09.
6. CON issued to replace and consolidate Charleston Memorial with Medical University by adding 138 beds (98 from Charleston Memorial, 15 from psych beds, 25 from conversion of rehab beds) for a total of 604 general beds 82 psych & 23 D&A beds, SC-03-60 10/14/03. On 1/30/08, 78 general and 15 psych beds were transferred from Charleston Memorial to MUSC and the 25 rehab beds at MUSC were converted to general acute beds. Charleston Memorial was licensed for 20 acute care beds; MUSC was licensed for 584 acute care beds, 82 psych beds, and 23 substance abuse beds. Charleston Memorial de-licensed 11/25/08.
7. CON issued 5/31/06 to construct a replacement hospital with 40 additional beds for a total of 140 acute beds, SC-06-26. Facility reduced the number of additional beds at the replacement hospital from 40 to 30 on 2/27/09, for a total of 130 beds. Licensed for 129 beds 3/17/10.
8. CON issued 11/27/07 to convert the 25 nursing home beds in the Skilled Nursing Center to general acute beds for a total capacity of 296 general acute beds, SC-07-61. Licensed for 296 acute beds and the Trident Medical Skilled Nursing Center closed on 5/1/08.
9. CON issued 10/20/05 to construct a replacement hospital with a reduced bed capacity from 68 to 32 beds, SC-05-74. New facility licensed 7/15/08.
10. CON issued 4/12/07 to construct an LTCH with 34 LTCH and 6 nursing home beds that does not participate in the Medicaid program, SC-07-13. CON voided 4/15/08.
11. CON issued 10/20/04 to add 10 additional psych beds for a total of 70. SC-04-52. Licensed for 70 psych beds 3/25/08.

12. Converted from a High Maintenance Group Home to an RTF 3/18/10.
13. CON issued 9/14/06 for 60 additional non-Medicaid beds for a total of 192 nursing home beds, SC-06-56. Licensed for 192 beds 6/26/08.
14. Formerly Bamberg County Nursing Center.
15. CON issued 9/16/09 to add 16 beds for a total of 60, SC-09-43. CON voided 3/17/10.
16. CON approved 4/21/10 to construct a 120 bed nursing home that does not participate in the Medicaid program.
17. CON issued 3/28/07 to construct a 120 bed nursing home that does not participate in the Medicaid program, SC-07-11. Licensed 1/21/10.
18. CON issued 10/15/08 for 30 additional nursing home beds for a total of 135, SC-08-40.
19. 2007 utilization data.
20. CON issued 6/15/09 to add 26 nursing home beds for a total of 125 beds, SC-09-30.
21. Formerly Trinity Mission of Charleston. Licensed 9/4/08.
22. CON issued 2/14/08 to convert the 87 institutional nursing home beds to 87 general nursing home beds that do not participate in the Medicaid program, SC-08-09. License classification changed 2/14/08.
23. Formerly Orangeburg Nursing Home.

INVENTORY OF EMERGENCY FACILITIES 2008 UTILIZATION

CATEGORY	NAME OF FACILITY	COUNTY	CITY	2008 ER VISITS
REGION IV:	EMERGENCY FACILITIES			
II	AIKEN REGIONAL MEDICAL CTR	AIKEN	AIKEN	53,708
IV	ALLENDALE COUNTY HOSPITAL	ALLENDALE	FAIRFAX	8,120
III	BAMBERG CO MEMORIAL HOSPITAL	BAMBERG	BAMBERG	10,962
III	BARNWELL COUNTY HOSPITAL	BARNWELL	BARNWELL	12,675
III	BEAUFORT CO MEMORIAL HOSPITAL	BEAUFORT	BEAUFORT	36,666
II	HILTON HEAD HOSPITAL	BEAUFORT	HILTON HEAD	20,770
II	BON SECOURS ST FRANCIS XAVIER	CHARLESTON	CHARLESTON	38,920
II	CHARLESTON MEMORIAL HOSPITAL *1*	CHARLESTON	CHARLESTON	12,686
II	EAST COOPER MEDICAL CENTER	CHARLESTON	MT PLEASANT	17,742
(*)	MUSC MEDICAL CENTER	CHARLESTON	CHARLESTON	57,903
II	ROPER HOSPITAL	CHARLESTON	CHARLESTON	70,207
II	TRIDENT MEDICAL CENTER	CHARLESTON	CHARLESTON	59,813
III	COLLETON MEDICAL CENTER	COLLETON	WALTERBORO	21,519
II	SUMMERVILLE MEDICAL CENTER	DORCHESTER	SUMMERVILLE	37,474
III	HAMPTON REGIONAL MEDICAL CENTER	HAMPTON	VARNVILLE	10,546
III	COASTAL CAROLINA MEDICAL CENTER	JASPER	RIDGELAND	14,956
II	REG MED CTR ORANGEBURG-CALHOUN	ORANGEBURG	ORANGEBURG	50,664
			TOTAL	535,331

1 Closed 11/24/08.
(*) Met insufficient criteria to be classified.

REGION IV:	TRAUMA CENTERS		
III	BEAUFORT CO MEMORIAL HOSPITAL	BEAUFORT	BEAUFORT
I	MUSC MEDICAL CENTER	CHARLESTON	CHARLESTON
III	ROPER HOSPITAL	CHARLESTON	CHARLESTON
III	BON SECOURS ST FRANCIS XAVIER	CHARLESTON	CHARLESTON
III	TRIDENT MEDICAL CENTER	CHARLESTON	CHARLESTON
III	REG MED CTR ORANGEBURG-CALHOUN	ORANGEBURG	ORANGEBURG